Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gloria L. Ware Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Greneral maryland N/A Baltimore HOSPital 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign Funeral Months Hours 0970471949 MaryTand 216-52-1154 Director 62 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be Funeral items 23a 21206 U.S.A. 5010 Kenwood Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedo... Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. o, ş 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify Black than "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Counselor Creative Options years Be Department of Health and Mental H Important: If item 27 is marked oth any injury or other transponen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Wade Carlean Nock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Ware(daughter) 5010 Kenwood Ave., Baltimore, MD 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 09/15/11 Baltimore, MD King Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 3dsephodes of Brown Jr. Funeral Home PA 2140 n. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ disease or condition dedical resulting in death) aminer Sequentially list conditions, if any backing Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit that the death certificate be executed resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Yes 2 No 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. ☐ Accident ☐ Suicide Investigation within 24 hours after deatl

To the Funeral Director,
completed filled in by the 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 8969 Name and address of person who completed cause of death (Item 23a) (Type, Print 1/and Jari Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RBRZ MOND Medical 4a. Facility Name of not institution, give street and number Town, or Location of Death 4c. County of Death **Examiner** Harford 222 Perryman Road #229 <u>Aberdeen</u> If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Director 1 **M**M 2 □ F 7 1940 70 Sept. show 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔼 No Maryland Aberdeen Harford 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral 1222 Perryman Road 21001 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 XXo Specify: If Yes, Give 3 Widowed 4 □ Divorced Specify: Black Completed Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygie is marked other Bell Man Resorts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Floyd Yarbray Samantha Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Audrey Irene Brown/Sister <u> 1222 Perryman Rd. Aberdeen,MD 21001</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 9-9-2011 Baltimore.MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home ullest 4210 Belair Rd. Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ je disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and strans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending ph d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death ed by the af Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 2 No Investigation 1 Tes Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a on who completed cause of death (Item 23a) (Type,

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	aryland / L	Certifica		eaith and i Death		Reg. N2 0		29503
	Physici	an	1. Decedent's Name (First, Middle, L						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	cal	Natalie L.	Yopconka		41.00	7			ber 12		
€	Examir	er	4a. Facility Name (If not institution, g			4b. Cit		Location of Death			nty of Death	
	Funeral		Harmony Hall A 5. Social Security Number 6.		1 NG ge (In yrs. last bir		er 1 Year	mbia If Under 24 Hrs.	8. Date of Bir	th	ward 9. Birthi	place (State or Foreign
	Director		203-01-1023	1□M 2□XF	93	Yrs. Months	s Days	Hours Min.	June 2	4, 191	8 Penr	nsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	ith the Marylar or 28a-f show	ē		2								1 ☐ Yes 2 ☐ No
	the h	iec	MD Howar 10e. Street and Number	<u>a</u>	<u>La</u>	urel 10f. Z	Zip Code			10g. Citizen	of What Cou	
	h with	Funeral Director	8641 Tower Dr.	ive			20	723			USA	Α
	ems erm	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Dec	edent of His	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No	- 14. F	Race - Ameri	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	1 □Yes 2 🙀 If Yes, Give Year or Dates:	No		2 X No		, , , , , , , , , , , , , , , , , , , ,	Spe		nite
5-("natu	Completed	15. Decedent's I (Specify only highest g	Education rade completed)	16a.	Decedent's Us (Give kind of w	sual Occupa vork done du	tion uring most of work	ring	16b. Kind of	f Business/In	ndustry
12	within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or	5+)					0.		
d 2	filed Hygi Sther ent, I	Be Co	17. Father's Name (First, Middle, Las			Homema		18. Mother's Nam	e (First, Middle,		wn Hom name)	1e
<u>la</u> n	lld be fental rked c	To B	Jacob Panek					Caro	line Ba	rmiis		
ary	shou s ma		19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailing Addres	ss (Street a	nd Number or Ru			vn, State, Zi,	p Code)
Σ,	and 2 ealth n 27 I		Carol Eigenbro	de/Daughte					aurel,		723	
ore	ges 1 t of H if iter or oth		20a. Method of Disposition	☐ Removal from State	20b. Place of cemeter	Disposition (Nature) Disposition (Nature) Disposition	ame of other place)	Date	20c. Locatio	on - City or To	own, State
Baltimore, Maryland	t. Pag tment tant:		4 □ Donation 5 □ Other (Spec	ify)	Gate			m. 9/17				.ng, MD
Bal	permit Depar Impor any In		21. Signature of Funeral Service Lice	BMOOK	М01103			^{s of Facility} Do t Avenue			al Hom 20707	
			23a. Part 1. Per the disease, or conshock, o heart failure. List onl	nplications that cause one cause on each I	d the death. Do i	not enter the mo	ode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Couse (Final disease or condition resulting in death)	_ a	Dementia						1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):						
		ē	Sequentially list conditions,	b. Due to (or as	a consequence of	of):					_	
the state	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Late 236 or nou y that initiated events	200 10 (01 20	a comoquemo (
P.	be executed sician and burial-transit	Exa	resulting in death) Last	c Due to (or as	a consequence	of):	 -					· · · · · · · · · · · · · · · · · · ·
68760,0	tificate be executed ig physician and as the burial-transit	edical		▲ d								
	ertifica ling pl	100	IF FEMALE:							1		
Вох	The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use a	by Physician/N	23b. Was decedent pregnant in the past 12 months?		2 Fetal death						Date of deliv	very Day Year
Ö	he de	ysic	1 ☐ Yes 2 ☐ Xuo 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 ☐ Other (specify)					
σ.	that the ned by 1 detach	H.	Part II. Other significant conditions	contributing to death t	out not resulting in	the underlying	cause giver	n in Part I.	23e. Did t	obacco use c	ontribute to	the cause of death?
Records,	quires n sigr ald be	d b							1 🗆 '	Yes 2∏ No	o 3□ Pro	bably 4 🗌 Unknown
000	aw requir as been s 2 should	Completed							24a. Was	an 24	b. Were aut	opsy findings available ompletion of cause of
Re	The Is	E O							autop perfo 1 □ Yes	rmed?	prior to co death? 1 ☐ Yes	
Vital	sician: The certificate rector, pagi	Be C	25. Was case referred to medical					26. Place of Deat			1 🗆 162	2XXNo
of V	∯ .≅ .≅	၉ .	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Ou	tpatient 3 ☐ [Other	r: 4 🗆 Nursing He	ome 5 Resi	dence 6 🔀	Other (Spec	Assisted ify) Living
n o	Ing After	Certification:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	ury 28b. 1 ay, <i>Year)</i> li	ime of njury	28c. Injury Work?		28d. Describe I	how injury occ	curred	
isic	Patt :: 9	icat	2 Accident investigation 3 Suicide 6 Could not		At home for	M	L	es 2□No	006 1 1 6	0		10 / 10 /
Division	after Direction by	ertif	4 Homicide determined	building, el	ury - At home, far c. (Specify)	im, street, iacto	ry, onice		City or To	street and Nu vn, State)	mber or Hur	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi	Medical C	29a. Certifier 1 X Certifying F (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis	of examination an	, death occurre d/or investigation	ed at the tim on, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) and date and place	I manner as ce, and due	stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and marrier st	aleu	2:	9c. License	number		29d. Date sig	ned (Month	, Day, Year)
	F>F0		•	//	1		D/	17447				
	7.		30. Name and address of person wh	complete 10 11	death (Item 23a) (Type, Print)	D4	± / 4 4 /		ser	rembe	r 12, 2011
	4		Andrew Laz			Cedar	Lane.	Suite	103.	Columbi	ia, MD	21044
	Sta		()		ar's Signature	Barks						
	Registr	ar	CED 1 5 2	111 /D	4 1	Marka						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra/AMEND#29dperMD, 9/2/11; EMW, McCo Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ August 26, 2019 Francois Tzvi Assal 6:53 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Country) Tunisia 1 X M 2 - F Months Days Min. (MOT) 87/1938 72 **Director** 065-36-5529 Usual Residence of Decedent show 10a, State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Bethesda 1 Yes 2 X No Montgomery 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? variment of Health and Mental Hygiene. oortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be i Funeral 6008 Roosevelt Street U.S.A. 20817 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Electrical Engineer Comsat Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ment. Important: If item 27 is marked any injury or out. Victor Assal Sultana Krieh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Ruth Assal - Spouse 6008 Roosevelt Street, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 08/30/2011 Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MO1524 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner 08/24/11 01653 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ု့ဝ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this appleted filled in by the funeral director. 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D66896 1900 8 (26/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Madison Leonard, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) AUG 3 1 2011 State Registrar

State of Maryland / Department of Health and Mental Hygiene [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael Adamchak Month 8 Year Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Wicomico Salisbur center If Under 1 Year If Under 24 Hrs (In yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 148-44-9045 1 🕅 2 🗆 F 6/25/1953 Director Usual Residence of Decedent items 23a or 28a-f show 10a. State 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director Berlin MD Worcester 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11522 Quillin Way USA 21811 permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items amy injury or other traumatic event; the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, as Decede... _ med Forces? ∀ Yes 2 □ No Black, White, etc. ģ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) auditor Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Teodore Adamchak Anna Macek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan Adamchak/wife 11522 Quillin Way Berlin, ND 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) State Cremat 8/25/2011 Millsboro DE 21. Signature of Funeral Bervice Licensee 22. Name and Address of Facility 108 William Burbage Funeral Home Berlin MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or his rt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autons perform 1 Yes 2 No Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? 2 XNo Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Suicide 1 Yes 2 No Investigation 2 Accident
3 Suicide
4 Homicide within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 1 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of pers pleted cause of death (Item 23a) (Type, Print) Simona BA9+1 Carroll St. Salisbu 100€ State AUG 29 201 Registrar Jack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Physician/ 725AM Vita Rose Arena 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Coastal Hospice at the lake Solisbury Wicomice 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TxF Months Days Hours Min 188-22-4022 **Director** 83 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 58 Birdnest Dr. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ģ 2 X No Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: white Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ALCOA Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Aguanno Lena Alfana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seafarer Lane, Ocean Pines, MD 21811 Frances Mancino / sister 112 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ ther (Specify) Springhill Mem. Pk 9/10/2011 Hebron, MD 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Immediate Cause (Final Onset and Death Physician TESTETIL disease or condition) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linju that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Year 4 Pregnant at time of death 9 Unknown After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2. No 1 🗆 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Acciden 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: After the function of the functin Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 24 hor To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

Bek LL

0 2011

BUX 1733 SAUSBURY, MD LIBO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 9:15 AMEdward Lee Brandenburg August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1778 Harvest Drive Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year, 1941 Hours 1 🖾 M 2 🗆 F Months Mary Land 69 **Director** 212-38-9129 Nov. Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland 10c. City. Town or Location notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral 23a 1778 Harvest Drive United States items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married ō \$ 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes Give "natural", 3 Widowed 4 Divorced Completed Year or Dates er than "natur ; the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 U.S. Government marked other t Research Technician Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Margaret Werking Rufus Brandenburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 Health tem 27 Frederick, Maryland 21702 Kelly Webb / Daughter 5804 Stonehouse Court item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o once. ŏ cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) 26, 2011 Olivet Cemetery Frederick, Maryland Mt. 21. Signature of F or ral Service Leen e 22 Name and Address of Facility Stauffer Funeral Homes, P.A Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the disease, or complications that care shock, or heart failure. List only one cause on each in ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Onset and Death Ph_sician/ Covana disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Universitying Cause (Disease or linjury Due to (or as a consequence of) and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown the detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of chiving obstructive 24a. Was an autopsy Anema 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this. within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State

or Attending Physician; The law requires that the death certificate be Box 68760 P.O. | Division of Vital Records, Hospital

31. Date filed (Mon State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

610 Registrar's Signatur

9th AVE, BRUNSWICK, MD 21711

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

2011

Anne Ludington Bell	1- For State	te of Maryland	DCpa	rtment o	i icaliii ali	d Menta	al Hygi	CHC			29508
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle, I ANNE BELL	_ast)						Date of Death Month August 27,			Time of Death 2323 hrs
	4a. Facility Name (if not institution, Queen Anne's Emerger				4b. City, Town, or Queenstow			,	4c. County of Queen Ar		
Funeral Director	0/1 00 0701	Sex 7. Age	(In yrs. la	ast birthday) Yrs	If Under 1 Yea Months Day		Adim	. Date of Birtl	1925	9. Birthpl Countr PENN	ace (State or Foreign ry) SYLVANIA
and show any nce.	Usual Residence of Decedent 10a. State 10b. County MD QUEEN A	NNE'S	-	Town or Locat							Od. Inside City Limits Yes 2 X No
vith the Maryland 23a or 28a-f she s notified at once	10e. Street and Number 416 QUARTER CR 11. Marital Status	EEK DRIVE	Ever in U	S 113. Wa	10f. Zip Code 21658 as Decedent of Hi	spanic Origi	n? (Specif		g. Citizen of Wha UNITED S	TATE	
hours after death with the Maryland natural?, or items 23a or 28a-f she Esaminer must be notified at once ed by Funeral Director	1 Never Married 2 Marr	ied Armed Forces? 1 Yes 2 ced If Yes, Give Year or Dates:	X No	If Y	es, specify Cuba Yes 2 X No n's Usual Occupa	n, Mexican, I	Puerto Ric	an, etc.)	White, Specify: 16b. Kind of Busi	etc. WHI	TE
7 3 1 7	Elementary/Secondary (0-12)	College (1-4 or 5		during m	ost of working life	e. DO NOT u	se retired)		OWN	HOME	
2121; Id be fill Mental F narked event, 1	17. Father's Name (First, Middle, La CHARLES TOWNSE 19a. Informant's Name/Relationship	ND LUDINGTO	N	19b. Mailin	g Address (Stre	CC	NSTAI	NCE CA	laiden Surname) MERON ber, City or Town,	State, Zi	p Code)
and 2 feath item 2 traum	SAMUEL BELL, I 20a. Method of Disposition 1 Burial 2 X Cremation			Place of Dispos	VER TERR ition (Name of ce ner place) E CREMAT	metery,	Di	ate	NEW YORK	City or Tov	wn, State
Baltimore, permit. Pages I a Department of ite Important: If ite injury or other to	4 Donation 5 Other Spec 21. Signature of Funeral Service Co	erisee		CENTER FE 40	lame and Addres LLOWS, H 8 S. LIB	s of Facility ELFEN ERTY	BEIN STREE	II, UEP	NAM FUNEI	RAL H	HOME, P.A.
Physician Medical Examiner	23a. Part I. Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	mplications that caused gach line. a. Multiple Injuries Due to (or as a conse			he mode of dying	, such as car	rdiac or res	spiratory arre	st, shock, or hear		Approximate Interval Between Onset and Death
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a conse c. Due to (or as a conse									
execuian and ial - tra	events resulting in death) Last UNPENDED	dAMENDED	querice of	· j.					<u> </u>	+	
ox 68 eath certi	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Yes 2 V No 9 Unknown 9 Unknown								Year		
rds, P.O. B requires that the d been signed by the hould be detached letted by Phy	Part II. Other significant condition		but not re	esulting in the u	inderlying cause	given in Part	t I.	1 Yes	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknow		
of Vital Records, P.O. ng Physician: The law requires that the this certificate has been signed by neral director, page 2 should be detacl or To Be Completed by First To Be Completed by First To Be Completed by First Page 1	25. Was case referred to medical				26 Plan	e of Death (C	Shook only	24a. Was a autops perform	sy pri m <u>ed</u> ? de		esy findings available apletion of cause of
n of Vital I ding Physician: After this certifi funeral director, on: To Be (examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗸	ER/Outpatient		IOshan —	Nursing H		Residence 6	Other:	
#_`~= <u> </u>	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	ation	ear)	28b. Time of I 2315 hrs	1	ıry at Work? Yes 2 ✓ I	No hui	imney fell rricane	ow injury occurred through hom	e skylig	
		(Specify) At h	ome knowledg	ge, death occur		ate and plac	416 e, and due	or Town, St Quarter C	ate) reek Drive, Que 	enstowr	
To the Howithin 24 h To the Fun Completely	one) 2 Medical Exami 29b. Signature and title of certifier	ner: Of the leasts of examend menuter stated.	nination ar	nd/or investiga	29c. Licens	se number	urred at the	e time, date a	and place, and du		
OCME	30. Name and address of person with Mary G. Ripple MD.	no completed cause of de			O.C. W. Baltimore		Raltimo	re MD 24:	August 28, 2	2011	
State Registrar	31. Date filed (Maching System)				vv. Dailimon		Jailiiiioi	.G, WID 2 1.			

Registrar DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 29509 State Registrar Amend#20b&20cperfureralhome%**JehilioalecohDeath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eleanor Aug 27. Elizabeth Burcher 11:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Director 282 18 9794 90 March 1 Ohio Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 🛶 No Prince George's Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o Funeral 6820 Groveton Drive United States 20735 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give Specify: Completed 3 Widowed 4 ☐ Divorced White Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Housewife Ow.n. Home it. Page 1 and 2 should be filed w rtment of Health and Mental Hygi rtant: If item 27 is marked other njury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Jesse Franklin Windom Eleanor Denny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Burcher Klemm (Daughter) 6820 Groveton Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other page 11 dens 9-2-2011 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1:
Department of I
Important: If its
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) (umk Rockledge, Florida (unk) FloridaMemorial 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service hip Ferry Road. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final Ph, i i n disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Day Month 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ပ္ 1 № Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending n 24 hours after death.

Re Funeral Director: A pleted filled in by the fu 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 📕 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of certifie on who completed cause of death (Item 23a) INE CENTER NB3 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AÜĞÜST 23. 2011 ALPHONSO BROOKS 00:32A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CENTER CLINTON Social Security Number 6. Sex 7. Age (In yrs. last birthday, if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. JUNE 11, 1942 WEST VIRGINIA **Director** 233–64–7020 69 Usual Residence of Decedent or 28a-f show notified at show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MARYLAND PRINCE GEORGES CLINTON 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 20735 UNITED STATES 3305 ORDEN COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 0 1 Never Married 2 Married ^{2 No} 1964ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: BLACK 3 Widowed 4 N Divorced Completed Year or Dates 1967 event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
12TH GRADE College (1-4 or 5+) LEAD LINEMAN POWER COMPANY marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNKNOWN MARY LUCILLE BROOKS or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 500 BEECH STREET, FORT WASHINGTON, MARYLAND 20744 TONGELIA BAILEY / GIRLFRIEND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) MARYLAND VETERANS CEMETERY AUGUST 31,2011 CHELTENHAM, MARYLAND iture of Funeral Service Little ee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 THORNTON JOHNSON MOO583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and trar resulting in death) Last Due to (or as a consequen physician the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other မ 1 Yes 2 🗌 Ner 1 Inpatient 2 IER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 Pes 2 No 5 Pending after death. 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29c. License number 29d. Date signed (Month. Dav. Year) 201 D0062057 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTHERN MARYLAND HOSPITAL NRSO SANDRA BANKS,

State

Registrar

32. Redistrar's Signature

7503 SURRATTS ROAD, CLINTON, MARYLAND 20735

M.D.

31. Date filed (Month, Day, Year)

AUG 3

			Please	Type or Print in Bla					00511
			For State	State of Maryland	-		Mental Hygier	5011	29511
			Registrar 1. Decedent's Name (First, Middle, Las	st)	Certificate of	Death	Reg. I	No.	3. Time of Death
п	Physicia Medic		Charles	Henzy	Brown	Sr.	Month	Day Year	2:12pm
	Examin		4a. Facility Name (if not institution, give	11 (11	4b. City, Town, o	or Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. S	ex 7. Age in vrs. last b	irthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgo:	lace (State or Foreign
	Director		LLO - 32-3903	XM2□F 85	Yrs. Months Days	Hours Min.	(Month, Day, Year	1926 Man	ry).
	land show d at	o.	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location			1	0d. Inside City Limits
	Maryli 28a-f otifiec	irect	Manyland Prince E	eurse 400	er Marl	مرو			1 Tes 2 No
	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Funeral Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Coun	try?
	death w	nne	500 N Harry S	12. Was Decedent Ever in U.S.	13. Was Decedent of H	774 Hispanic Origin? (Sp	ecify Yes or No-	14. Race - America	an Indian
36	s after dea al", or iter Examiner	امَ	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖈 No If Yes, Give	If Yes, specify Cub		Rican, etc.)	Black, White, e	
9	2 hours aft "natural", edical Exa	eted	3 Widowed 4 Divorced	Year or Dates.	Sa. Decedent's Usual Occur		101	Specify: 131a	
21215-0036	s filed within 72 hour tal Hygiene. sd other than "natul event, the Medical	Completed	(Specify only highest gra Elementary/Seconday (0-12)		(Give kind of work done life. DO NOT use retired	during most of worl	king	. Kind of Business Inc	ustry
121	d with fygien ther th nt, the	0	12		Trainer			Equestri	An
Maryland		10	17. Father's Name (First, Middle, Last)	R	own	18. Mother's Nan	ne (First, Middle, Maide	en Strname) R. J.	21.
lary	should and M is mar		19a. Informant's Name/Relationship (T		9b. Mailing Address (Street	00		or Town, State, Zip C	ode)
	" ± 01 T		Charles H. Brown		2318 Crain	Highway	. Upper M	Salbon Mi	20772
Baltimore,			20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □	Removal from State	of Disposition (Name of tery, crematory or other pla	ce)		Location - City or To	wn, State
altir	permit. Page Der artment Important: I any injury o once.		4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licens		22, Name and Addre		3-11 0	1 intu-	
8	Der Der Imp		Theresa 7	leal	Adams	Finen	Home B.	Agunso M	1) 20608
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	olications that caused the death. Do ne cause on each line.	not enter to pode of dyir	ng, such as cardiac	or respiratory arrest,	D	Approximate Interval Between
ō	hysician/ Medical		disease or condition resulting in death)	a. ASDICATIO		monia			Onset and Death
	Examiner	_	Sequentially list conditions	1 Drosepsis	3				
	sit sq	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a co sequence	e of):				
	executed an and rial-transi	Exal	that initiated events resulting in death) Last	C. Due to (or as a consequence	e of):				
90	ath certificate be executed attending physician and for use as the burial-transit	Completed by Physician/Medical Examiner	C	d					
68760	ertifical ding ph	/Mec	IF FEMALE:	220 If you contain the contain					
Вох	eath ce attend I for us	ician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 Ectopic pregnan 5 Other (specify)	су		23d. Date of delive Month	ry Day Year
O. B	t the de by the tachec	hys	9 Unknown	9 Unknown					
, P.O.	es thai signed be de	by	Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlying cause gi	ven in Part I.	- 1	o use contribute to th	
Records,	requir been (should	letec					1 L Yes		ably 4 Unknown
Seco	he law te has age 2 :	omo					autopsy performed?	prior to cor death?	npletion of cause of
tal	nysician: The lavinis certificate hadiector, page 2		25. Was case referred to medical examiner?		26. P	lace of Death (Chec	1 ☐ Yes 2 ☐ k only one)	No 1 🗆 Yes	2 □ No
of Vital	Physic this or	ဍ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/C 28a. Date of injury 28b.		4 ∐ Nursing H	ome 5 Residence		
o uc	nding ath. :: After e fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury wor		28d. Describe how inj	ury occurred	
Division	or Atter fter des irector	ertif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, to building, etc. (Specify)	farm, street, factory, office		28f. Location (Street a		Route Number,
۵	pural cours at eral D filled in	cal C	29a. Certifier 1 Certifying Phys					<i></i>	
	to the hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical Certificate:	Check 2 Medical Exami	ician: To the best of my knowledge ner: On the basis of examination and e Practioner: To the bast of my know	or investigation in my opini	on doath accurred a	t the time date and pla	on and due to the cour	anda) and manner stated
	Mithie Co = Co		29b. Signature and title of certifier		29c. Licens			Date signed (Mpnth, E	
			/ = / / / /				1	. /	
•		.co	20 Name of the state of the stat			1589	1 8	3/25/20	11
2	BZ	S(0)	30. Name and address of person who c	ompleter cause of death (Item 23a)	(Type, Print)		Ver Son	1	20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Braxton Biller August 28^{Day} 2011^{Year} 6:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 37750 Apache Road St. Mary's Charlotte Hall 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F 58 **Director** Mary Land 164-44-3307 25, Ian. 1953 er than "natural", or items 23a or 28a-f show the Me it a Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland St. Mary's Charlotte Hall 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37750 Apache Road 20622 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates. Maryland 21215-0036 should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 👿 No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Systems Technician Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Elwood Biller ೨ Vera Rose Patton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Dianna J. Biller/Wife 37750 Apache Road, Charlotte Hall, MD 20622 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Brinsfield Echols Crem. 08-29-2011 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ ponation 5 ☐ Other (Specify) Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. art 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Hypoventilation Syndrome oles terolemia Exami Cause (Disease or injury that initiated events sician and burial-trans resulting in death) Last Physician/Medical death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No ed by the detached t or Attending Physician: The law requires that the been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ♣ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to predical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne of Death 1 Natural completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending Accident
Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Cractioner. To the best of my knowledge death accurred at the time date and place, and due to the cause(s) and manner as stated. (Check dist the time date and place, and due to the 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pe who completed cause of death (Item 23a) (Type, Print RBG Manoj Panwala, Charlotte Hall, MD 20622 31. Date filed (Month, Day, Year) AUG 30 32. Re strar's Signature Registrar

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 295 | 3 State of Maryland / Department of Health and Mental Hygien 2011 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sept 2011 Veronica Beasley 1:05 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 38492 Townshend Road Coltons Point St. Mary's 5. Social Security Number Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Ohio 1 🗆 M 2 🖾 F Days Months Hours 63 Director 577-64-3956 1071371947 Ohio Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland St.Mary's Coltons Point 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 38492 Townshend Road 20626 USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No Specify If Yes Give 3 🗌 Widowed 4 🗆 Divorced Completed Specify: White Year or Dates er than "natura the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Care Giver Health Care 7 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Francis Otis Nina Ann Yeager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Joseph Beasley/Husband 38492 Townshend Road, Coltons Point, MD 20626 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or ot X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Saints Episcopal 09/10/2011 Avenue, MD 21 Survice Service Ser Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick Street, Leonardtown, MD 20650 Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ CENERRO VASCULAR ACCIDENT, Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Can con Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and tiff 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAMA ASSOCIATES MONYWOOD MD CILL MD 31. Date filed (Month, Day, Year) State Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bowen August 26 Mary Elizabeth 2011 11:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13106 Estelle Road Montgomery Silver Spring 5. Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth July 4, 1928 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 M 2 XF Days Hours 577-42-0025 Yrs. 83 **Director** Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified MD Montgomery Silver Spring 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13106 Estelle Road 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ken Specify: Specify: White er than "natural", the Medical Exar 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental i ရ Lawrence Leverett Bailey Elizabeth Kathleen Schweier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health au: If item 27 is Priscilla Metcalfe/Daughter 505 Norton Lane, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State Aug. 3 2011 Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Outer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cardiovascular Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Ovarian Cancer Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Pregnant at time of death 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Unknown signed by the best of the signal of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 Yes မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 MResidence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 ₹ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated **Certifying Nurse** Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 10 D68686 August 30, 2011 person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Frederick Min, MD

AUG 3 1 2011

31. Date filed (Month, Day, Year

🖋 32. Registrar's Signature

2101 Medical Park Drive, #200, Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 3. Time of Death 2. Date of Death Day **Physician** 12:40 PM August 28 2011 Norris Cusick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Prince Georges Clinton If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) Days Yrs. March 3, 1939 Maryland 217-34-0460 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 □ No Director Maryland Charles Waldorf 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 1753 Red Oak Lane 20601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No U.S. If Yes, Give Year or Dates: Navy 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 □Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th. PEPC0 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Cusick Nellie Hamilton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Jo Cusick/ Wife 1753 Red Oak Lane, Waldorf, MD. 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory Aug. 31, 2011 Waldorf, MD. 22. Name and Address of Facility Huntt Funeral Home mp(20 3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner rr any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by C 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2. No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death ;1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.O. | Records, of Vital Division

The law requires that the death certificate be executed and burial-tran physician a the burialas the signed by t d be detach certificate or Attending Physician: this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral To the Hospital

Funeral

Director

28a-f show

7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examitment be in diffed at

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 is marked other i any Injury or other traumatic event, III

Physician

/Medical

Examiner

Saltimore, Maryland 21215-0036

State Registrar

Medical

29a, Certifier

31. Date filed (Month,

29b. Signature and title of certifier

Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 🗸 [2 ANSARI

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 29516 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month PM 6:27 Maust EDITH LILLIAN WHITING CLARK 2011 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 1 M 2 T F Days Hours JULY 8, WASHINGTON, D.C. Vrs 1939 72 578-56-1342 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 □ No CLINTON MARYLAND PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 6601 OAK ORCHARD COURT 20735 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates. 1 ☐ Yes 2X No Specify: Specify: BLACK 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT FEDERAL GOVERNMENT 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AGNES YOUNG WHITING PAYTON WHITING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20735 6601 OAK ORCHARD COURT, CLINTON, MARYLAND JOHN CLARK / HUSBAND 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HARMONY MEMORIAL PARK AUGUST 30,2011 HYATTSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Ltc. see THORNTON FUNERAL HOME, P.A. LYDIA C. THORNTON JOHNSON 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or iinjury him to forms a consequence off that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death Month Day 9 Hlnknown ditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autops, performed. death? 1 Yes 2 No 1 Yes

Ph_sician/ Medical Examiner Examine

Physician/

Medical

10a. State

Examiner

Funeral

Director

or 28a-f show notified at

ral", or items 23a o Examiner must be

er than "natural", or i

permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other any injury or other traumatic event, the

Department of Health Important: If item 27 any injury or other to once.

ě

Director

Funeral

by

Completed

Be

ပ

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

requires that the death certificate be executed as the burial-tran and physiciar use

ò detached signed by be should has page 2 funeral director. after death.

Director: Aft
d in by the fur filled in by

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law

24 hours

within 2 To the I

сопретер

Physician/Medical

Completed by

Be

၉

Certificate:

Medical

IF FEMALE:

Part II. Other si	gnificant cond
25. Was case re examiner?	ferred to medi

2 X No

1 Yes

1 X Natural

Accident

Suicide

4 Homicide

29a. Certifier

nedical	0
	Hosp

Manner of Death 5 Pending Investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury

(Month, Day, Year)

building, etc. (Specify)

28b. Time of 28c. Injury at iniury 28e. Place of Injury - At home, farm, street, factory, office

work?
1 Yes 2 No

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Other:

26. Place of Death (Check only one)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number

4 Nursing Home 5 Residence 6 Other (Specify)

City or Town, State) 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

9b.	Signat	ture and title of certifier Human	Kze	rdlq	

D21883

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL

AUG 30

32. Registrar's Signature

State

Registrar

11-06407 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James L. Curran, III State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) 3. Time of Death Month Day August 25, 2011 1733 hrs Medical Examiner James 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6104 Old Branch Avenue Temple Hills Prince George's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** 7. Age (In vrs. last birthday) Foreign Country) MD Months Days Hours Director 52 Nov 29, 1 V M 2 F 1958 216 74 6871 Usual Residence of Decedent 10d. Inside City Limits iny 10c. City. Town or Location 1 Yes 2 Who Maryland Prince George's Camp Springs more, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5203 Oahu Court 20748 United States Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 1 Yes 2 X No specify: \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Federal Elementary/Secondary (0-12) College (1-4 or 5+) 12 Locksmith/Plumber/ Pipefitter Government. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) partment of Health and Mental Hiportant: If item 27 is marked ury or other traumatic event, James Lawrence Curran, II æ Barbara Scott 19a. Informant's Name/Relationship (Type, Print) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Curran (Wife) 5203 Oahu Court, Camp Springs, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 XX Cremation 3 Removal from State Lee Crematory Aug 29. 2011 Clinton, MD Donation 5 Other Specify 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Signature of Funeral Service Licensee Ferry Road, Clinton, MD 20735 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the leath certificate be executed Physiclan/Medical UNPENDED g physician g AMENDED Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 this 1 Yes 28a. Date of Injury (Month, Day Year) Aug 25, 2011 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27 Manner of Death Certification: Subject shot self 1717 hrs Natural 1 Yes 2 ✔ No death. Pending the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗹 Suicide Could not be or Town, State) 6104 Old Branch Avenue, Temple Hills, MD within 24 hours aff To the Funeral D completely filled in determined (Specify) Parking Lot Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. aignature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 26, 2011 and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** melia 5:07 am Colly 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collingswood Nursing & Rehab Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)

Jan. 14, 1 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🖫 F Yrs 198–18–2310 88 1923 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I've Madical Examiner must be rediffed at any injury or other traumatic event, I've Madical Examiner must be rediffed at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ₩ No Maryland Bethesda. Directo Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6124 Swansea Street 20817 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Pszcolka Frances 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Callan Daughter 6124 Swansea St., Bethesda, Md. 20817 20b. Place of Disposition (Name of cemetery, crematory or other place Aug. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 25, 2011 Charles Cemetery Indian Head, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Williams Funeral Home, P.A. 21. Signature of Funeral Service L M00668 23a. Part 1. Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h art ailure. List only one cause on each line.

Immediate Cause 1 inal 4270 Hawthorne Rd., Indian Head, Md. 20640 Approximate Interval Between Onset and Death **Physician** 0169111 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** De menting Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 1 No certificate 1 □ Yes 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8/32/201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Z133 Hueley 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien & U for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month 0 0310 M ZABE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Mandrin Inpatient Care Center Harwood If Under 1 Year I If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Days Hours Min Months 02/14/1941 Washington, DC 70 215-38-6565 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20657 12456 Sedalia Trail United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates item 27 is marked other than "natural", other traumatic event, the Medical Exa Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Defense Contractor Technical Editor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file h and Mental I is marked of မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is mark... any injury or ... Clarence Oliver Bennett Louise Monsell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis Campaigne/Husband 12456 Sedalia Trail, Lusby, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 09/05/2011 Charlotte Hall, MD 21. Simulated Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Cther (specify) in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 9 Unknown Unknown P.0. certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv 2 🗌 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NOther (Specify) MANDRIN 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred HOUSE injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation M Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature a 29d. Date signed (Month. Day, Year) 12360 eron 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29520
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

		•	For State Registrar	State of Mi	ai yiai iu /	•	tificate of E	ieaith and iv Death		Reg. No.		
П	DI VIVI		Decedent's Name (First, Middle, L.	ast)					2. Date of Dea	ith	Vaca	3. Time of Death
	Physicia Medic		Donald	Lee	Coe	:			Septemb	Day	1, 2011	10:35PM
	Examin	er	4a. Facility Name (if not institution, gi			- 1	4b. City, Town, or				County of Death	
	Funeral		Meritus Medical 5. Social Security Number 6.		e (In yrs. læst bi	rthdav)	Hagers If Under 1 Year	town If Under 24 Hrs.	8. Date of Birth	_	lashingto	on blace (State or Foreign
	Director		214-46-7310 Usual Residence of Decedent	1 X M 2 □ F	67	Yrs.	Months Days	Hours Min.	Jan 25,		4 Mary	Tand
	and Show	١	10a. State 10b. County		10c. City, Tov	vn or Loc	ation				1	0d. Inside City Limits
	Maryli 28a-f	rect	Maryland Washin	gton	Boon	sbor	0					1 X Yes 2 □ No
	a or 2	a Di	10e. Street and Number				10f. Zip Code			•	zen of What Cour	itry?
	th with ms 23 must	Funeral Director	31 High Street	T		1	21713		<u> </u>	U.S		
'	or itel	by Fu	11. Marital Status1 ☐ Never Married2 ☒ Married	12. Was Decedent E Armed Forces? 1 \(\sum \) Yes 2 \(\frac{X}{2}\)	ver in U.S.	- 1		spanic Origin? (Spe n, Mexica <i>n</i> , Puerto	Rican, etc.)		 Race - Americ Black, White, 6 	
ğ	rs afte ıral",	ed b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 X No	Specify:			Specify: Whi	Lte
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest of		16	(Give k	ent's Usual Occupa	ation uring most of work	ing	16b. Kii	nd of Business Inc	dustry
121	ithin 7 ene. • than he M	Som	Elementary/Seconday (0-12)	College (1-4 or 5		life. DC	NOT use retired)			Δα	ricultur	٠_
م م	filed wi al Hygiv d other event, t	Be	17. Father's Name (First, Middle, Last	,		ralm	er	18. Mother's Nam	e (First, Middle, i			
/lan	d be fi denta irked tic ev	욘	Vincent Spiker	Coe				Catheri	ne Viv	ian	Beahm	
ary	d 2 should be falth and Menta 27 is marked ir traumatic ev		19a. Informant's Name/Relationship		19	b. Mailing	g Address (Street a	and Number or Rura	al Route Number	; City or	Town, State, Zip (Code)
€,	and 2 Health em 27 ther tr		Roxanna K. Coe /	Wife	_		gh Stree		oro, Ma			
שסר	Page 1 ament of Hant: If ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		cemet	ery, crem	ition (Name of atory or other plac	e)	Date		cation - City or To	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Special Sign Sure of Fundal Service Lice		[Green]							t, Maryland Home, PA
Ba	permi Depar Impo any ir		Laule	Dage				ational P				21713
П			23a. Part 1. Enter the disease, or conshock or heart failure. List only	nplications that co sed one cause on each line	the death. Do	not enter	the mode of dying	g, such as cardiac o	or respiratory arm	est,		Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	. /.	noni						1	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	consequence		1					
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence		yphyse	ma_				
	uted d ansit	Examiner	cause. Enter Underlying Cause Disease or impury that initiated events	C	V		0				J.	
	exectian an	Ĕ	resulting in death) Last	Due to (or as a	a consequence	of):			_			
90	law requires that the death certificate be executed has been signed by the attending physician and le 2 should be detached for use as the burial-transit	Nedical		d							-	
687	ertific ding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy						23d. Date of deliv	en/
Box 68760	eath o atten d for u	Physician/N	in the past 12 months?	1 ☐ Live Birth 4 ☐ Pregnant a	2 🗌 Fetal dea		Ectopic pregnance Other (specify)	у			Month Month	Day Year
С	the d by the	hys	9 🗌 Unknown	9 Unknown					1			
, P.O.	ss that igned be de	by	Part II. Other significant conditions	contributing to death b	ut not resultino	in the ur	iderlying cause giv	en in Part I.	23e. Did to			ne cause of death?
rds	requir	etec										psy findings available
eco	e law e has b ge 2 s	Completed							24a. Was a autop perfo		prior to co death?	mpletion of cause of
<u>~</u>	Physician: The lav r this certificate has ral director, page 2		25. Was case referred to medical	1			26. Pla	ace of Death (Chec	1 Yes_k only one)	2 No	1 ☐ Yes	2 ∐ No
ĬŽ	nysicii nis cer direc	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/C	Outpatient	3 □ DOA Othe	er: 4 Nursing Ho	ome 5 🗆 Resid	lence 6	Other (Specify	()
o l	ing Pl	ate:	27. Mann of Death 1 ✓ Natural 5 □ Pending	28a. Date of inju (Month, Day		Time of injury	28c. Injury work	? _	28d. Describe h	ow injury	occurred /	
sior	ttend death stor: / / the f	Certificate:	Accident Investigati 3 Suicide 6 Could not	be 280 Place of Inju	In/ - At home	farm etra		Yes 2 □ No	28f Location /S	traat and	d Number or Rura	I Poute Number
Division of Vital Records,	al or A s after Il Dire		4 ☐ Homicide determine	building, etc		arri, ou	01, 140101, 311100		City or Tow			, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Example (Check 2 Medical Example)		kamination and	or investi	gation, in my opinio	n, death occurred a	t the time, date a	nd place,	, and due to the ca	use(s) and manner stated.
	Го the within Го the хотріє	Σ	only one) 3 ☐ Certifying Nu 29b. Signature and title of certifier	rse Practioner: To the	pest of my kno	wiedge, d	eath occurred at the 29c. License				e) and manner as st te signed (Month,	
			▶ A	Infut.	MO		D3	25 18		9/	3/11	
	70 /-		30. Name and address of person who	completed cause of de	eath (Item 23a)		-	7.0		-/-	1	
J	W-6		Robert Guedenet				-	le, Mary	Land 2	1756		
	Stat Registra	_		1019 Just	Josephalure 8	Sol	alla					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2952 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2, Rayetta May Crampton 2011 12:33 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3651 Harpers Ferry Road Sharpsburg Washington Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🕱 F July 13, 1934 Mary land Director 212-32-5764 77 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Sharpsburg 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3651 Harpers Ferry Road 21782 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo "natural", or Completed by 1 Never Married 2 X Married 1 Yes 2XXNo Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry 2 should be filed within 72 m ith and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rex Henry Seaton Nellie May Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra Richard F. Crampton - Husband 3651 Harpers Ferry Rd. Sharpsburg, MD 21782 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX Surial 2 Cremation 3 Removal from State cemetery, crematory or other place, Mt. View Cemetery 09-06-2011 Sharpsburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service I 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport,MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 21 years Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir sician and burial-transit that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Myocardial Infarction Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Uterine Cancer 24a. Was an page 2 s has autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 X No To the Hospital or Attending Physician: Twithin 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending iniury hours after death.

uneral Director: After the function of the work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, pleted filled in by 4 - Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Tom D0066288 September 2, 2011

JW-3

Baltimore, Maryland 21215-0036

68760

Box

P.0.

Records,

Division of Vital

State Registrar Tania Crussiah, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 Byrkit Drive Williamsport, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ELIZABETH Month Day Vear ROSE CHESLOSKY \mathbf{A}^{M} SEP 7:30 Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death 7635 CAROL ROAD PORT TOBACCO CHARLES Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth
(Month, Day, Year)
MAR . 12, 1928 **Funeral** 9. Birthplace (State or Foreign 1 M 2XX Months Days **Director** 159-24-3707 PENNSYLVANIA Yrs. 83 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES PORT TOBACCO 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral 7635 CAROL ROAD 20677 U. S. A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. <u>۾</u> 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Maryland 21215-0036 1 Yes 2X No Specify: Completed 3℃Widowed 4 □ Divorced Specify: WHITE Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the HOMEMAKER OWN HOME other traumatic event, Be filed It. Page 1 and 2 should be artment of Health and Mental Hy " tem 27 is marked of " anatic eve 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ FRANCIS D. CHAPLINSKY MARY CHEMOHOWSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRIS WALLINGSFORD/DAUGHTER 7635 CAROL RD., PORT TOBACCO, MD 20677 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD VETS.CEMETERY 4 Donation 5 Other (Specify) 16, 2011 CHELTENHAM, MD Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acu disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) that the death in the past 12 months? Pregnant at time of death Month Day Year 2 🗆 No 9 Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' ☐ Yes 2 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 300 Other: ျာ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Watural 5 Pending 2 Ccident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Division of Vital Records,

State

29a. Certifier

31. Date filed (Month, SEP 15

29b. Signature and title of certifier

30. Name and address of person who complete

DHMH 17 Rev 7/2009

Registrar

0

ed cause of death (Item 23a) (Type, Print)

32. Regigrar's Signature

1_____Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 In the decided Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene

2	0		1	2	q	5	2	
	U	1		6	7	J	4	٩

		1- For State Registrar		Certificate o	of Death		Re	eg. No.	
Physic Medical Exam		1. Decedent's Name (First, Middle, L John Patrick C	allahan				2. Date of Dear Month August 31	Day Year , 2011	3. Time of Death 0700 hrs
}		4a. Facility Name (if not institution, 109 Manor Drive, Apt. A3			4b. City, Town, o Hagerstow		eath	4c. County of Washingt	
Funeral Director			Sex 7. Age (In M 2 F 60	yrs. last birthday) Y	If Under 1 Ye Months Dar		Hrs. 8. Date of Bir Min. June 1	th(MM/DD/YYYY) 5, 1951	9. Birthplace (State or Foreign California Country)
yland -f show any once.	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Washing		City, Town or Loc Hagers tov	vn				10d. Inside City Limits 1 X Yes 2 No
h the Maryland 3a or 28a-f she	Director	109 Manor Dr.	Apt. A3		10f. Zip Code 21740)	11	0g. Citizen of Wha	t Country?
ifter death with 11", or items 23 her must be no	y Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce	and 12. Was Decedent Ever Armed Forces? 1 X Yes 2 1 1 S, Give Year 1 978	lf No.	Vas Decedent of H Yes, specify Cuba	n, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	- 14. Race - White,	American Indian, Black, etc. White
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f ah. mustic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify Elementary/Secondary (0-12) 12	only highest grade complete College (1-4 or 5+)	ed) 16a. Decede	ent's Usual Occupa most of working life	tion (Give kind	of work done retired)	16b. Kind of Busi	ness/Industry
21215-0036 and be filed within? Mental Hygiene. marked other than	Be Cor	17. Father's Name (First, Middle, La John Minot Calla					ame (First, Middle, M Cance Bake		
e, MD 2121 1 and 2 should be fi Health and Mental item 27 is marked r traumatic event,	To	19a. Informant's Name/Relationship Susan Callahan-c	laughter	306	C North	Colonia	or Rural Route Num 1 Dr. Hag		State, Zip Code) MD 21742
Baltimore, permit. Pages 1 and Department of Heal Important: If iten		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spec 21. Signature of Funeral Service Lice	Removal from State	crematory or company of the Smithsbu	other place) rg Crema	tory 9	Date - 2-2011	Smithsb	
Bal permi Depar Impo		Kaitlin Zolta	non Sut	. 1	331 East	ern Blv	d. North	Hagersto	uneral Home wņ, MD 21742
Physician /Medical £xaminer	1 T	23a. Part I. Enter the disease, or confailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	nplications that caused the ceach line. a. Atherosclero Due to (or as a consequer	tic Card				est, shock, or hear	t Approximate Interval Between Onset and Death
	e	Sequentially list conditions, if any, leading to immediate	b						
d sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequer						
760, icate be executed physician and the burial - transit	/Medical E	X UNPENDED	d. amended23a,pt	.II,27,p	er me,g9	19 9-26-	-11 sm	•	
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of 1 Live birth 4 Pregnant at time vn 9 Unknown	2 F	etal death 3 Other (Specify)	Ectopic pre	gnancy	23d. Date of do Month	elivery Day Year
he d he		Part II. Other significant condition	contributing to death but			given in Part I.			ute to the cause of death?
n of Vital Records, P.O. Box 68 ding Physician: The law requires that the death certi. h. After this certificate has been signed by the attending fromeral director, page 2 should be detached for use as	leted by	Chronic Obstru	ctive Pulmona	ry Disea	se		24a. Was a	an 24b. We	Probably 4 Unknown ere autopsy findings available
tal Reco	Completed						autop: perfor 1 ✓ Yes 2	med? dea	or to completion of cause of ath? Yes 2 No
Vital Rechysician: The I	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	2 ER/Outpatier		of Death (Che	rsing Home 5	Residence 6	Other: Scene
Division of Vital Records, P.O tal or Attending Physician: The law requires that trs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac		27. Manner of Death 1 X Natural 5 Pending		28b. Time of	· · · _ ·	ry at Work?		now injury осситес	
Divisi Hospital or Att 24 hours after d	Certification:	2 Accident Investige 3 Suicide 6 Could not determine	ot be 28e. Place of Injury -	At home, farm, str	eet, factory, office	ouilding, etc.	28f. Location (S or Town, St		or Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical C		cian: To the best of my kno er:On the basis of examinat and manner stated.						
F 3 F 3	M	29b. Signature and title of certifier	// XX		29c. Licens			29d. Date signed August 31, 2	(Month, Day, Year)
		30. Name and address of person wh					NB 0455	71	
<u>s</u>	ate	31. Date filed (Month, Day, Year)	Assistant Medical Exa		vv. Baltimore S	treet, Baltin	nore, MD 2122	3	
Regis		SEP 1 5 2011 \(\alpha\)	knews B. K	parker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 | 1

		1 - State Registrar	Ce	rtificate of Deat	h	Reg. No.	29524
Phys	ician	1. Decedent's Name (First, Middle, Last) Henrietta Dods	on		2. Date of De Mor © n / 1		3. Time of Death
	edica						IVI
	mine	7309 Chicamuxen Court		4b. City, Town, or Locati Brandywine	e		George's
Fune Direc	_	577 56 8576 1 M 2 F	Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year If Un Months Days Hou	rs Min. 8. Date of Bir 5/2/01	9. Bit 942	thplace (State or Foreign puntry) DC
ar at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
Maryla 18a-f		MD Prince George'	s Brand	ywine			1 🎖 Yes 2 🗆 No
with the I	Finoral Director	10e. Street and Number 7309 Chicamuxen Court		10f. Zip Code 20613		10g. Citizen of What Co	ountry?
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23 aor 28a-f show item traumatic event, the Medical Examiner must be notified at	hy E	11. Marital Status 1 Never Married 2 Married 12. Was Deceder Armed Forces 1 Yes 2	²³ No	Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or No- ican, Puerto Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
-003 ours at atural"	Pot	3 Widowed 4 Divorced If Yes, Give Year or Dates		1 ☐ Yes 2X No Spe	cify:	Specify:Bla	
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary (Seconday (0-12) College (1-4 c	(Give life. L	edent's Usual Occupation kind of work done during r DO NOT use retired)	nost of working	16b. Kind of Business	
Id 2	Be C		Pens.	ion Clerk	lother's Name (First, Middle,		al Worker
faryland should be filed and Mental Hy is marked oth	٢	Frank Johnson			net Brown	waden damane)	
e, Mar and 2 shoul Health and I tem 27 is m		19a. Informant's Name/Relationship (Type, Print) Tonya Dodson/ Daughte.			mber or Rural Route Number en Ct.Brand		
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposementery, cre. Resurred	osition (Name of matory or other place)	Date 9/2/2011	20c. Location - City or Clinton,	
Baltimo	ouce.	21. Signature of Funeral Service Licensee	mu 2	2. Name and Address of Fa 294 Old Was	shington Ro	onic Fune	ral Home MD 20601
		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each I	ed the death. Do not ent	ter the mode of dying, such	as cardiac or respiratory ar	rest,	Approximate Interval Between
Ph _y sici Medic		Immediate Cause (Final disease or condition resulting in death)	lung	Cancer		- 0	Onset and Death
Examin	_	Due to (or a	s a consequa ce of):				
	ine.	Sequentially list conditions, b. Due to (or a cause. Enter Underlying	s a consequence of):				
executed an and rial-transi	Examiner	Cause (Disease or injury that initiated events c. Due to (or a resulting in death) Last Due to (or a	s a consequence of):				
raf 60 tificate be executed ng physician and s as the burial-transit	ica Te	d					
certificate be nding physicials use as the burners.	Medical	IF FEMALE:					
BOX 6 death cer ne attendi ed for use	Physician/		n 2 Fetal death 3 t at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
that the ned by the detack	, Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause given in P	rart I. 23e. Did t	obacco use contribute to	the cause of death?
ICONGS, P.O. law requires that the ras been signed by the second be detach	ted by						robably 4 🗆 Unknown
VITAI RECOTOS, ysician: The law requires is certificate has been sig director, page 2 should b	Completed				24a. Was auto perfo 1 □ Yes	osy prior to death?	topsy findings available completion of cause of
ician: certifical	Be (25. Was case referred to medical examiner?			Death (Check only one)	211101	2 110
Physical direction	<u>اد</u>	1 lnpa	atient 2 ER/Outpatien		Nursing Home 5 Resid		rify)
on con conding ath.	icate	1 ☑ Natural 5 ☐ Pending (Month, D	Day, Year) injury	work? M 1 Yes 2	_	now injury occurred	
DIVISION OF all or Attending Pl s after death. al Director: After th ed in by the funeral	Certificate:		njury - At home, farm, str etc. (Specify)	eet, factory, office	28f. Location (S City or Tou	Street and Number or Ru n, State)	ral Route Number,
DIVISION OF VITAL REP To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate in completed filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the best of Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the basis of certifying Nurse Practioner: To the basis of only one)	examination and/or inves	tigation in my opinion death	n occurred at the time date a	and place, and due to the	rausals) and manner stated
Vith to the		29b. Signature and title of certifier		29c. License numbe	er	29d. Date signed (Month	
		Jeffar mo		DZZ57	4 mo	8/29/1	/
235	3	30. Name and address of berson who completed cause of Robert T PACE 1207	. 11.	1' - 1 -	2 WAlder F	MD 2060	2
S Regis	tate		trar's Signature	le se stal	14111-411		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 ear Physician/ 24, 6:45 A M Howard Jerome Decker August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 1215 Mentor Ave. Capitol Heights 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth **Funeral** 6. Sex 7. Age (In yrs. last birthday) May 4, 1925 Days 1 🛛 M 2 🗆 F New York Director 068-18-8964 86 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Capitol Heights Maryland Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1215 Mentor Ave United States 20743 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 1XXX Yes 2 □ No If Yes, Give 1945—1966 Year or Dates 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Issac Decker Amanda Countrymen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Decker (Wife) 1215 Mentor Ave, Capitol Heights, MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery Sept 1, 2011 Cheltenham, MD 21. Signat of Funeral Service Licer 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MO1555 Ferry Road, Clinton, MD 20735 23a. Plan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Sarcomatoid Lung Cancer Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Gastic Carcinona, 1 Yes 2 No 3 Probably 4 Unknown Daroxysmal Afrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy Iliac Artery pade performed? Aneurysm 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 only one) 29d. Date signed (Month, Day, Year) Signatul D31001 25/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RBIOT 7500 Greenway Center Dr. Greenbelt, MD 20770 Suite 430 Stuart Turkewitz, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 26

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 29526 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 31 20119:25 Α Delia Marie Dayton August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Charlotte Hall Charlotte Hall Veterans Home 8. Date of Birth
(Month, Day, Year)
08-31-1928 Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Days Hours Country) California Director 83 009-16-7320 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No Maryland St. Mary's Charlotte Hall 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ŏ 23a Funeral 29449 Charlotte Hall Rd. 20622 USA items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14 Race - American Indian Was Decedent Ever Armed Forces? 1

Yes 2 □ No If Yes, Give Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Schould be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Clerical 12 Office Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Delia (Unknown) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic Edward Platt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
St. Mary's Department of Aging
P.O. Box 653, Leonardtown, MD 20650 Rebecca Cranston/Guardian 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem 09/01/2011 Charlotte Hall, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of FacilityBrinsfield-Echols F.H., P.A. M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Priysician/ NUMONIA disease or condition Medical resulting in death) Due to (or as a con-Examiner if any, leading to Immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequ the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 400 ed by the a 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed **Director:** After this certificate in by the funeral director, pag 1 ☐ Yes 2 ☐ No I ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury ■ Natural work? 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 2011 who completed cause of death (Item 23a) (Type, Print) address of person VP) MD, 22333 Greenview Parkway, Great Mills, Stephen P. Cafferty,

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

32. Regis

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 4:07 A M Shirley Wren Dugan September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 22680 Cedar Lane Court Leonardtown St. Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Yo 1 □ M 2**X** F Months Days Year) Hours 1927 West Virginia Director 235-34-7663 Yrs 83 Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 1 ☐ Yes 2X No Maryland St. Mary's Hollywood 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 26036 Sotterley Heights Road 20636 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Completed 3 Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene 12 County Government Librarian Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other traumatic even ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ <u>William</u> Deggs Wren Marian King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26046 Sotterley Heights Rd., Hollywood, MD 20636 <u>Bryan Dugan / Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) John's 9-6-2011 Hollywood, Maryland Signature neral Service Consee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, M00052 22955 Hollywood Road Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. Sevene Dement's disease or condition Medical resulting in death) or as a consequence of Examiner んといかりのつ Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [조 Completed 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? this certificate 2 🗌 No ☐ Yes 25. Was case referred to nedical Be 26. Place of Death (Check only one) Assisted $_{
m Living}$ examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 6 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at After 1 Natural 5 Pending work Accident 1 🗌 Yes 2 No Investigation 24 hours after deatler Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 62213 2 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22650 Cedar Lane Court Leonardtown, Maryland 20650 Suresh Patel, M.D.

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month)

istrar's Signature

6 201

SEP 0

11-06561 Jarred Channing	1	mario State o	r Print in Black I of Maryland / Dep Ce		of Health ar		Hygiene	2011 g. No.	29528
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)				-	2. Date of Death	n	3. Time of Death
Medical Examii	ner	Jarred Channing D					Month August 31,	2011	1045 hrs
		4a. Facility Name (if not institution, give 11 W. Baltimore Street #11			4b. City, Town, o		eath	4c. County of Death Washington	
Funeral		Social Security Number 6. Security Number	7. Age (In yrs.	last birthday)	If Under 1 Ye			h (MM/DD/YYYY) 9. Birt	
Director		218-04-0597	м 2□F 28	Yı	Months Da	ys Hours	Min. Aug. 2	6,1983 Foreig	untryMaryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loca	ation				10d. Inside City Limits
	ъ	Maryland Washin	gton	Hage	rstown				1 X Yes 2 No
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 11 W. Baltimore	Street		10f. Zip Code 2174	0	10	og. Citizen of What Cour	ntry?
with th	— L	11. Marital Status	12. Was Decedent Ever in			lispanic Origin?	(Specify Yes or No-		can Indian, Black,
or iten	Fune	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No				erto Ricari, etc.)		1. 4
s after	à	3 Widowed 4 Divorced 15. Decedent's Education (Specify on	of Dates:		Yes 2 X N		of work done	Specify: 7,	hite ndustry
2 hour	ted	Elementary/Secondary (0-12)	College (1-4 or 5+)		most of working li				
036 ithin 7 one.	Completed	12	0	Ъ.	agger			grocery	store
filed w Hygie d othe		17. Father's Name (First, Middle, Last)					ame (First, Middle, Nabeth DeM		
212' Ild be Mental Marke	o Be	Jerry A. Tracey 19a. Informant's Name/Relationship (Ty	ype, Print)	19b. Maili	ng Address (Str			ber, City or Town, State P.O. Box	, Zip Code)
AD 2 shout and 3 27 is mastic		Roberta DeMario -	grandmother	302	N. Anti	etam St	., Funkst	own, Maryla	nd 21734
re, rand Titem	1	20a. Method of Disposition 1 Burial 2 X Cremation 3		. Place of Disponent	osition (Name of o other place)	cemetery,	Date	20c. Location - City or	Town, State
Pages Pages nent of ant: I		4 Donation 5 Other Specify:	Ha		wn Crema	-	9/6/11		n, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		21. Signature of Funeral Service Licens	Minnes	/	Name and Addre			FUNERAL HO	
Physician		23a. Part I. Enter the disease, or complifailure. List only one cause on ea	lications that caused the dea	th. Do not enter	the mode of dyin	g, such as card	iac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease a.	Hypertensive Atheros		diovascular D	isease			Death
7		h	Due to (or as a consequence	of):					
	ē	cause Enter Underlying Cause	Due to (or as a consequence	of):					
ed nsit	cal Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):					
lox 68760, eath certificate be executed a attending physician and for use as the burial - transit		UNPENDED	AMENDED						
760, icate be physic the bur	an/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pro			3 Ectopic pr		23d. Date of deliver	y Day Year
. Box 68760, he death certificate be e y the attending physicia hed for use as the buria	ician	past 12 months?	1 Live birth 4 Pregnant at time of		Fetal death Other (Specify)	SEctopic pi	egitaticy	l lile	
Boy re death the att	Physici	1 Yes 2 No 9 Unknown	9 Unknown		1.12	iv in Dad I	220 Did to	obacco use contribute to	the cause of death?
		Part II. Other significant conditions Obesity	contributing to death but no	t resulting in the	e underlying caus	e giveri in Pait i			pably 4 Unknown
ords, law r-quir has b en si 2 sh uld b	etec						24a. Was		utopsy findings available completion of cause of
Ceco The law ate has	Completed by						perfo 1 ✓ Yes	rmed? death? 2 No 1 ✓ Y	es 2 No
Vital Revysician: The his certificate director, pag	Be	25. Was case referred to medical examiner?	Januital:			Other			
f Vit	P	1 ✓ Yes 2 No 27. Manner of Death	lospital: 1 Inpatient 2	ER/Outpatie		njury at Work?		Residence 6 Othe	r: Scene
on of nding Pl th. r: After re funera	io ii	1 ✓ Natural 5 Pending	(Month, Day,Year)		1	Yes 2 N			
ivisior I or Attend after death Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not	290 Place of Injury - At	t home, farm, st	reet, factory, offic	e building, etc.	28f. Location (Street and Number or Ri	ural Route Number, City
Di Hospital of 24 hours at Funcral I	Cert	4 Homicide determined	(Specify)						
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed be completely filled in by the funeral director, pag. 2 sh uld be detailed to the funeral director, pag. 2 sh uld be detailed to the funeral director, pag. 2 sh uld be detailed to the funeral director, pag. 2 sh uld be detailed to the funeral director, pag. 2 sh uld be detailed to the funeral director, pag. 2 sh uld be detailed to the funeral director, pag. 2 sh uld be detailed to the funeral director, pag. 2 sh uld be detailed to the funeral director of the fun	Medical	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of my knowler: On the basis of examination	edge, death oc n and/or investi	curred at the time, gation, in my opin	, date and place ion, death occul	e, and due to the caus rred at the time, date	se(s) and manner as sta and place, and due to the	ted. ne cause(s)
To the within 2 To the Complet	Med	29b. Signature and title of certifier	and manner stated.			ense number		29d. Date signed (Mo	
		D-701			0.0	C.M.E.		September 1, 20	011
_		30. Name and address of person who			O M Politica	ro Street D	altimore, MD 21	1223	
		Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)	Assistant Medical Ex	ature a	DATE:	ore Street, B	aitiiiiole, MD 2		
S Regis	tate		1799	1	South !				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. K. U Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 Francis Xavier Davis 27 Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional medical Wicomico (cnter alisburi **Funeral** . Sex 1 ☐ M 2 🛣 F Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth Months 107671928 215-24-8891 Director 82 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiene Z7 is an artiked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b Count 10c. City, Town or Location Director 10d. Inside City Limits MD Worcester Ocean City 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Gulf Stream Dr. 21842 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 X Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Shop WOrker Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Martin Leo Davis Anna M. Hochrein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ann Shepherd 30784 DuPont Blvd., Dagsboro, DE 19939 niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 9/1/2011 Eastern Shore Vet. 4 Donation 5 Other (Specify) Hurlock, MD Funer ervice Licenses Burbage Funeral 22. Name and Address of Facility 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death ungeni disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) ding physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live of death in the past 12 months? Month Day Year Yes 2 No be detached 9 I Unknown g 🗌 Unknown P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? nas 24a. Was an page 2 performed certificate 1 Pyes 2 No Yes 2 No Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No ၉ Other: this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 7. Manner of Death Certificate: 28b. Time of After 4 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work? death, Accident 2 No Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 \(\text{Homicide} \) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) within To the 29b. Signature and le of certifier 29d. Date signed (Month, Day, Year)

State Registrar Date filed (Month, Day,

DHMH 17 Rev 7/2009

9

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Amended iten = State Registrar #19a, perF. Home, 8/31/11, BA Certificate of Death WCHD . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 08-4:ZZAM 26-201 Catharine Lewis Eftimiadi Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisburg WICOMICO Diceat **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 KF Days Hours Months Min 7/11/1921 Country) 90 183-12-8877 Yrs Director VA Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director notified 28a-f 1 Yes 2 X No VA Accomac **Greenbackville** 10e. Street and Numbe 0 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 2011 Bayfront St. 23356 USA Effimiad 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 5 Completed by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: "natural" 3 - Widowed 4 - Divorced white Year or Dates er than "nature the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. <u> Interior Textile Designer</u> Design Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elwin Lewis Catharine E. Sharpley 19a. Informant's Name/Relationship (Type, Print) Son Nemiroff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 146 Old Kings Hwy., New Caanan, CT 06840 Peter Gibb Cropper Nemiro 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Greenbackville Cemi. 9/3/2011 Greenbackville, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun Service Lice Burbage Funeral Home 22. Name and Address of Facility 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ BNDOWRTRIAI WALLGNANT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence or): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physicis eted filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 menths?

1 Yes 2 No
9 Unknown Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 🗆 1 Yes 2 NO 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify HOSPICK 2 1 No Certificate: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Matural Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 1005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 10 6 HUIAM WASR 130 p SAZISBURY UND 21802 1737 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State AUG 3 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 and 2 should be filed within 72 hours after death with the Maryland f Heath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director		Mary's		ty, Town or Lo Lexingt		ark					10d. Inside City Lim	
	ith the l	ralDi	10e. Street and Number				10f. Zip					itizen of What	Country?	
	eath w tems 2 er mus	Fune	21275 Lexwood 11. Marital Status	12, Was Decede	nt Ever in U.	S. 13. \	Vas Deced	0653 lent of Hispa	anic Origin? (S	pecify Yes or No-	_	.S.A. 14. Race - A	merican Indian,	
36	after d al", or i Examin	d by I	1 Never Married 2 Marrie 3 Widowed 4 M Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date		- 1		ify Cuban, N 2 X No S	Mexican, Puert Specify:	o Rican, etc.)		Black, W Specify: D	hite, etc. Lack	
2-0	2 hours "natur edical E	Completed by	15. Decedent (Specify only highes	's Education	5.	16a. Deced	lent's Usua	al Occupatio	on ing most of wo	rkina	16b.	Kind of Busine		
21215-0036	vithin 7; giene. er than the Me	Com	Elementary/Seconday (0-12)	College (1-4	or 5+)	life. D	o Notuse ne Mal	retired)	ng mode or wor	ning] ,	Own Hor	ne	
bue	should be filed within 72 h and Mental Hygiene. 7 is marked other than "fraumatic event, the Med	To Be	17. Father's Name (First, Middle, La	*		<u> </u>		18	8. Mother's Na	me (First, Middle	_	Surname)		
Maryland	nould be nd Mer s marke umatic	-	John Jefferson 19a. Informant's Name/Relationship			19b. Mailir	a Address	(Street and		Mae Coo		r Town State	Zin Cade)	
	and 2 sh Health a tem 27 is		Joe John Fisher	r / Son		1	-			Laure]			•	
Baltimore,			20a. Method of Disposition 1	3 Removal from St	ate (Place of Dispo cemetery, crem	natory or of	ther place)	0.2	Date	l		or Town, State	
altir	permit. Page Department o Important: If any injury or once,		21. Sin atom of uneral Se	есіту)	Pan	rk Hall 22				1-2011 insfield		ark Hal neral H	Home, P.A.	
8	9 9 E E 8		Laward N. Brins			0052 2	2955	Holly	wood R	oad Leor	nard		Maryland 20	650
	Physician		23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final	ornplications that causely one cause on each	line.	tn. Do not ente	er the mode	e ot dying, s	such as cardiad	or respiratory ai	rrest,		Approximate Interval Between Onset and Death	
	Medical Examiner		disease or condition resulting in death)	a	as a conseq	uence of):								
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseq	uence of):								
	sit of	1.2	cause. Enter Underlying											
	and tran	xarr	Cause (Disease or impury that initiated events	c. Due to for	20.0.00000	uanaa afi:							2 1	
0	be execute sician and burial-tran	ical Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):								
98760	rtificate be executed ling physician and e as the burial-transit	edical	that initiated events resulting in death) Last	d										
Box 68	e death certificate be execute the attending physician and thed for use as the burial-tran	edical	that initiated events resulting in death) Last	d	me of pregna	ancy	Ectopic p	oregnancy ecify)				23d. Date of Month	delivery Day Year	
P.O. Box 68	s that the death certificate be execute gned by the attending physician and e detached for use as the burial-tran	Physician/Medical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown Part II. Other significant condition	d	me of pregnath 2 Petront at time of over	ancy al death 3 D death 5 D	Other (spe	ecify)	in Part I.	23e. Did 1	obacco	Month	,	
P.O. Box 68	requires that the death certificate be execute been signed by the attending physician and hould be detached for use as the burial-tran	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	me of pregnath 2 Petront at time of over	ancy al death 3 D death 5 D	Other (spe	ecify)	in Part I.	1 🗆	Yes 2	Month use contribute	Day Year to the cause of death? Probably 4 🛣 Unknown	
P.O. Box 68	w requires that the death certifics been signed by the attending should be detached for use as	Physician/Medical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown Part II. Other significant condition	d	me of pregnath 2 Petront at time of over	ancy al death 3 D death 5 D	Other (spe	ecify)	in Part I.	1 24a. Was auto	Yes 2 an	Month use contribute No 3 24b. Were prior	Day Year to the cause of death? Probably 4 🗶 Unknown untopsy findings availate to completion of cause of	ole
P.O. Box 68	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use a	Completed by Physician/Medical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown Part II. Other significant condition	d	me of pregnath 2 Petront at time of over	ancy al death 3 D death 5 D	Other (spe	ecify)	in Part I.	1 24a. Was auto perfu	Yes 2	Month use contribute No 3 24b. Were prior	Day Year to the cause of death? Probably 4 🗶 Unknown autopsy findings availate to completion of cause of the second se	ole
P.O. Box 68	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use a	To Be Completed by Physician/Medical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown Part II. Other significant condition CHF DVT	d	me of pregnath 2 Fettont at time of even with but not respect to the property of the property	ancy al death 3 death 5 death 5 death 5 death 5 death 5 death	dt 3 DO	26. Place Other:	of Death <i>(Che</i>	1 ☐ 24a. Was auto perfrict 1 ☐ Yes ck only one)	Yes 2 an psy primed? 2 1	Month use contribute \(\subseteq \text{No} 3 \subseteq \) 24b. Were prior death \(\text{lo} \) 1 \subseteq \(\text{1} \)	Day Year to the cause of death? Probably 4 X Unknown under the cause of death? Probably 4 X Unknown death of cause of cause of the c	ole
P.O. Box 68	ing Physician: The law requires that the death certifi 1. Mer this certificate has been signed by the attending uneral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	me of pregnath 2 Fettont at time of even with but not respect to the property of the property	ancy al death 3 death 5 death 5 death 5 death	dt 3 DO	26. Place OA Other: Sc. Injury at work?	of Death <i>(Che</i>	1 24a. Was auto perful 1 Yes ck only one)	Yes 2 an psy primed? 2 1	Month use contribute \(\subseteq \text{No} 3 \subseteq \) 24b. Were prior death \(\text{lo} \) 1 \subseteq \(\text{1} \)	Day Year to the cause of death? Probably 4 X Unknown under the cause of death? Probably 4 X Unknown death of cause of cause of the c	ole
vision of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certific death. ctor. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	Certificate: To Be Completed by Physician/Medical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcoment of the left of the	me of pregnath 2 Fet et at time of et at tim	ency al death 3 death 5 death 6 death	d t 3 Do	26. Place Other: 3c. Injury at work? 1 Yes.	of Death <i>(Che</i> 4 Nursing H	24a. Was auto perfu 1	Yes 2 an psy primed? 2 N h	Month use contribute No 3 24b. Were prior death 1 6 Other (Screen or other service)	Day Year I to the cause of death? Probably 4 X Unknown autopsy findings availate to completion of cause of the cause of t	ole
vision of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certific death. ctor. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	Certificate: To Be Completed by Physician/Medical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcomes 1 Live Bir 4 Pregnar 9 Unknown 1 Live Bir 1 Live Bir	me of pregnath 2 Fetting for a time of or month but not reside the but not reside the but not reside to the bu	eancy al death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 6 death	t 3 DO M Det, factory,	26. Place DA Other: ac. Injury at work? 1 Yes.	e of Death (Che 4 Nursing H s 2 No	24a. Was auto perfit Yes ck only one) Rome 5 Resi 28d. Describe 28f. Location (City or Tou	an psy primad? 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Month use contribute No 3 = 24b. Were prior death of Other (Sp. ry occurred) and Number or as a and due to the second	Day Year I to the cause of death? Probably 4 Unknot autopsy findings availate to completion of cause of the cause of th	ole of
vision of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certific death. ctor. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcon 1	me of pregnath 2 Fetting for a time of or month but not reside the but not reside the but not reside to the bu	eancy al death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 6 death	nderlying c t 3 D0 M pet, factory, eccured at tigation, in n leath occurr	26. Place DA Other: ac. Injury at work? 1 Yes.	e of Death (Che 4 Nursing H s 2 No ate and place, a death occurred me, date and place	24a. Was auto perfit Yes ck only one) Rome 5 Resi 28d. Describe 28f. Location (City or Tou	an psy primary of the state of	Month use contribute No 3 = 24b. Were prior death of Other (Sp. ry occurred) and Number or as a and due to the second	Day Year I to the cause of death? Probably 4 Unknot autopsy findings availate to completion of cause of the	ole of
vision of Vital Records, P.O. Box 68	or Attending Physician: The law requires that the death certificate death certificate and the strending irector. After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use a	Certificate: To Be Completed by Physician/Medical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcomes 1 Live Bir 4 Pregnare 9 Unknown 1 Unknown 1 1 Input 1 1 Input 1 1 Input 28a. Date of (Month, out be led 28e. Place of building, 28e. P	me of pregnath 2 Fetting Fetting Fetting for the but not reside the but not resident	ency al death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 6 death	t 3 DO M Det, factory, in rigidation, in rigidation, in rigidation, in rigidation and research accounts.	26. Place A Other: 3c. Injury at work? 1 Yes office	e of Death (Che 4 Nursing H s 2 No ate and place, a death occurred me, date and pla umber	24a. Was auto perfit Yes ck only one) Rome 5 Resi 28d. Describe 28f. Location (City or Tou	an psy ormed? 2 In Manager 1	Month use contribute No 3 24b. Were prior death 1 Other (Sc. ry occurred and Number or see, and due to the see, and due not the see, and manner as e, an	Day Year I to the cause of death? Probably 4 🗶 Unknown autopsy findings availat to completion of cause of the security. Probably 4 🗶 Unknown autopsy findings availat to completion of cause of the security. Pural Route Number, stated. Internal Route Stated. Inth, Day, Year)	ole of
Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certific death. ctor. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	Certificate: To Be Completed by Physician/Medical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live Bir 4 Pregnar 9 Unknown 1 Live Bir	me of pregnath 2 Fetting for the pregnation of the best of men of pregnation of the best of men of the best of the be	ency al death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 2 death	t 3 Do Note: factory, occurred at t igation, in meath occurred.	26. Place 26. Place Other: 3c. Injury at work? 1 Yes office the time, dainy opinion, cred at the time License nuc.	e of Death (Che 4 Nursing H s 2 No ste and place, a death occurred me, date and place aumber 7495	24a. Was auto perfit Yes ck only one) Rome 5 Resi 28d. Describe 28f. Location (City or Tou	an psy 2 an psy 3 an and psy 2	Month use contribute No 3 24b. Were prior death of Other (Sp. ry occurred and Number or each and manner as e, and manner as e, and manner at esigned (Moept. 1;	Day Year I to the cause of death? Probably 4 X Unknot autopsy findings availate to completion of cause of the cause of th	ole of

DHMH 17 Rev 7/2009

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

	For State Registrar	(Einst Mindell-		riaryian		tificate of L		F	Reg. N		2953	
n/ al	CHARLES	Decedent's Name (First, Middle, Last) HARLES EDWARD FOREMAN							2. Date of Death 08/24/2011		3. Time of De 5:30 A	
er	4a. Facility Name (if not institution, give street and number) Shady Grove Genesis Health Care 5. Social Security Number 6. Sex 7. Age (In yrs. Ia							4c. County of Death Montgomery				
	218-30-4 Usual Residence of	406	1 X M 2 □ F	30	Yrs.	Months Days		8. Date of Birth (Month, Day)		9. I	Birthplace (State or Fo	
rector	10a. State				10c. City, Town or Location Gaithersburg						10d. Inside City L	
Funeral Director	10e. Street and Number 40 N. Summit Avenue, #5			1	10f. Zip Code 20877			10g. Citizen of Wh			Country?	
<u>۾</u>	11. Marital Status 1X Never Married 2 ☐ Mamed 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent I Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give Year or Dates.		?_	ŀ	Was Decedent of Hispanic Origin? (Sper f Yes, specify Cuban, Mexican, Puerto f 1 ☐ Yes 2 ※ No Specify:		ify Yes or No- lican, etc.)	Black, White		,		
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5			5+)	· I ==			g	16b. Kind of Business Industry			
o l	5th 17. Father's Name (First, Middle, Last) Howard Levi Foreman, Sr.				Farmer 18. Mother's Name (Familing (First, Middle, Maiden Surname) urray				
						Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Summit Avenue, #5, Gaithersburg, MD 20						
1	1 X Burial 2 ☐ Cremation 3 ☐ Removal from State				emetery, cren	sition (Name of natory or other place Comm. Ch	:e) [/2011		ocation - City		
	21. Signature of Funeral Service Livensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD											
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Aterial fibrillation Due to (or as a consequence of): COPD Due to (or as a consequence of):											
→ I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deaded time of deaded time of deaded time.				ıl death 3 🗌	death 3 Ectopic pregnancy				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the unc					nderlying cause giv	, , ,			use contribute to the cause of death		
Completed by	autopsy prior performed? death									autopsy findings avai o completion of caus ? fes 2 \(\sumbole \) No		
<u> </u>	25. Was case referred examiner? 1 Yes 2 27. Manner of Death 1 X Natural 2	No	g 28a. Date of inj (Month, Da	ury	ER/Outpatien 28b. Time of injury	t 3 DOA Other	4 ₩ Nursing Hom / at 28				ecify)	
	4 ☐ Homicide determined 28e. Place of Injur building, etc.											
Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20b. Signature and title of certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29d. Date signed (No. 1) 29d. Date signed (No.									0 1	11 1	
-	OD Names and 1			1	00.1 7		7001			<i>U</i> 1	0. [] /	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤊 🎧 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Allen Goldsmith August 2011 9:00P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11910 Frere Place Newburg Charles Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 😾 M 2 🗆 F Months Days Hours June 4, 1943 213-46-5369 Director Country) Maryland 68 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Charles Newburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11910 Frere Place 20664 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after al Hygiene. d other than "natural", o 1 ☐ Yes 2 No Specify. White 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental h Archie Theodore Goldsmith Rena Louvina Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health ar If item 27 is Dallas Goldsmith/Brother 16415 Sycamore Drive, Cobb Island, MD 20625 20a. Method of Disposition permit. Page 1 a Department of H 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Brinsfield-Echols Crem.8/26/2011 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State any injury or 4 Donation 5 Other (Specify) Charlotte Hall, MD M00945 Signature of Funeral Service Licensee 22 AREHARTECHOUS FUNERAL HOME, P.A. St. Mary's Ave. La Plata, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed to (or as a consequence of physician s the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by Records, the Hospital or Attending Physician: The law requires 1 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛱 No Other: 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 KNatural 5 Pending after death. 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the land of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title o 29d. Date signed (Month, Day, Year) 00008370 August 24, 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) Payl LaPlata mo Blds 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29534 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 23 2011 Year WALTER DAVID GUTRICK, SR. 07:01 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES FORT WASHINGTON FORT WASHINGTON MEDICAL CENTER Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢 F Days JAN. 26, 1946 MARYLAND Director 213-44-3673 65 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director FORT WASHINGTON MD PRINCE GEORGES 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral UNITED STATES 20744 8100 ALCOA DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces 0 Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 2**X** No 1 ☐ Yes 2 XNo Specify: "natural" 3 Widowed 4 Divorced Specify: BLACK Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOUSE PAINTER SELF EMPLOYED 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARIE PROCTOR CLARK GUTRICK WALTER GUTRICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA W. GUTRICK/WIFE 8100 ALCOA DRIVE, FORT WASHINGTON, MARYLAND 20744 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State injury or 8/29/2011 4 Donation 5 Other (Specify) CEDAR HILL CEMETERY SUITLAND, MARYLAND Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 LADIA C. THORNION JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death ed by the a detached t Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTIVE HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? MYPERLIPIDEMIA 24a. Was an autopsy 2 No Yes 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA ဂ္ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

RB6

Box 68760

P.O.

Records,

of Vital

Division

Registrar

VERGHESE

(Check

only one) 29b. Signature and title o

SURESH

11701 LIVINGSTON 32. Registrar's Signature

PHYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D53782

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ROAD. SUITE #101, FORT WASHINGTON,

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Benjamin George Goldsmith August 30, 2011 1:47 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 14555 Goldsmith Farm Place Waldorf Charles Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Min Hours (Month, Day, Year 58 Director 219-58-7825 1953 Washington, DC June 16 ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location e filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Charles Waldorf Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral United States 20601 14555 Goldsmith Farm Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces 2 1 Yes 2 No 14. Race - American Indian ò Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", If Yes, Give White Completed Specify: 3 Divorced 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should : e filed within 72 ment of Health and Mental Hygiene tant; if item 27 is marked other than lury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 **SMECO** Meter Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin G. Goldsmith, Sr. Agnes Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14555 Goldsmith Farm Place, Waldorf, MD 20601 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Janice E. Goldsmith/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Crem 09/02/2011 4 Donation 5 Other (Specify) Charlotte Hall, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause neach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2-60 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Ş. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 nknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has perform 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 No Hospital: Other: 욘 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Dea Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending neral Director: A Investigation 1 🗌 Yes 2 🔲 No ⊥ Aeciden □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Eertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2 U 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2011 9:30 p 09 Gaulke Lois Jeanine . Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Mechanics ville 39035 Pond View Lane 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Hours Country) Minnesota Min. 12/27/1935 Days 1 🗆 M 2 🕱 F 476-32-5388 Director Usual Residence of Decedent 10d. Inside City Limits items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 😿 No **Mechanicsville** St. Mary's Maryland 10g. Citizen of What Country? 10e Street and Number Funeral USA 20659 39035 Pond View Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Examiner Black, White, etc. Armed Forces by 1 Never Married 2 Married 2 X No "natural", or ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates Medical 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the State Government Social Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Department of Health and Mental Important; If item 27 is marked of any injury or other traumatic eve 2 **Hulda** Graese Page 1 and 2 should be Lehmann William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 39035 Pond View Lane, Mechanicsville, MD 20659 Lisa Tennyson/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🗆 Burial 2 😾 Cremation 3 🗀 Removal from State Alexandria, VA 09/02/2011 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 22. Name and Address of Facility
Mattingley—Gardiner Funeral Home, P.A.
41590 Fenwick Street, Leonardtown, MD 20650 of Funeral Service Liger /ar Approximate Interval Between Onset and Death 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. , or heart failure. List only one cause on each line Immediate Cause (Final METASTATE ENDOMETRIAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, it any, reading to intractional cause. Enter Underlying Dunity (or as a consequence of): Examine Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Day in the past 12 months?

1 Yes 2 No
9 Unknown Month for Pregnant at time of death 9 I Inknown should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Tyes hin 24 hours after death.

the Funeral Director: After this npleted filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2/2011 D6884 KHAN, M.D of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address ST- MART'S HOSPITAL 25500 POINT LOOKOUT Rd. AMIR KHAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

		1 - State Registrar Certificate of Death Reg. No.															
Physic	cian	1. Decedent's Name (First, Middle, Last) 2. Date of Death MARY EDNA GREEN 2. Date of Death										Vear	3. Time of Death				
	dica						N						AŬĜÜST	28	2	2011	9:39 P ^M
Exam	nine	r	4a. Facility Name (if not institution, UNION HOSPIT	_	street and nui	mber)			4b. City,		Location	of Death		4c	. County		
Funer		4	5. Social Security Number	6. Se	×	7 Age	(In vrs las	st birthday)	If Unde		LKTON If Under	24 Hrs.	8. Date of Bir	th		CEC	LL place (State or Foreign
Funera Directo			215-56-5100		☐ M 2 X F	, . r . gc	61	Yrs.	Months	Days	Hours	Min.	JULY 3	y, Year)	50	Coun	MARYLAND
We		- 1	Usual Residence of Decedent			· · · · ·											
yland f shc ed at		<u> </u>	10a. State 10b. County				10c. City,	Town or Lo	cation							1	10d. Inside City Limits
Mar 28a-		<u></u>		EC]	L	\perp					TKIO	Ŋ		_			1 √Yes 2 □ No
ith the			10e. Street and Number 513 BO	ЭТТ	יים פיים	err.			10f. Zip	Code	2192 ⁻	1	ŀ	10g. Ci		What Cour	
ath w		runeral	11. Marital Status		12. Was Dec		er in U.S.	13.3	Vas Deced	lent of Hi			cify Yes or No-	_			STATES can Indian,
or its		Ž	1 ☐ Never Married 2 ☐ Marr	ied ,	Armed F	orces?		l l	Yes, spec	ify Cuba	n, Mexicar	, Puerto	Rican, etc.)		Black	k, White,	etc.
ural",			3 ☐ Widowed 4 🔯 Divorced	[If Yes, Gi Year or D	ve		1	☐ Yes	2 X No	Specify:				Specify:	BLA	ACK
"nati		ed [15. Deceder (Specify only highe			1)	-	16a. Deced (Give	kind of wo	k done a	ation luring mos	t of work	ing	16b. K	and of Bu	usiness In	dustry
idalica z 1 z 1 z 2 z 2 z 2 z 2 z 2 z 2 z 2 z 2		Сотріете	Elementary/Seconday (0-12)	Т	College (1-4 or 5+	+)		O NOT use		IG TEX	HNT	ידבאז	D	нарм	ΔCET!	TICAL
Hygi ent, t		o F	17. Father's Name (First, Middle, L	ast)				1221	011101	URLIN	-		e (First, Middle,				TIGE.
l be fi fental rked tic ev	1,5	۹	LEROY H. SEWE	ш,	SR								r betty				
should be filed within 7 is marked other than 7 is marked other than traumatic event, the M		Ī	19a. Informant's Name/Relationsh					19b. Mailir	g Address	(Street a	and Numbe	er or Rura	ıl Route Numbe	er, City or	r Town, S	tate, Zip (Code) 19709
Tey, Wall yially Z. I.Z. I.S. COOO 1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. If Heath and Mental Hygiene. The Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at			DAWSON GREEN	, J	R (S	ON)		14 W	. SHA	KESP	EARE	DRIV	Æ, MID	DLET	OWN,	DEL	
			20a. Method of Disposition 1 Burial 2 □ Cremation	з 🗆	Removal from	n State		ace of Dispo metery, cren			e)		Date	20c. L	ocation -	City or To	own, State
t. Page 1 tment of rtant: If it			4 Donation 5 Other (S	pecify)		BOH	EMIA I			<u> </u>	<u>_</u>)3/11	CHE	SAPE	AKE (CITY, MD
permit. Page Department of Important: If any injury or	ouce	-	21. Signature of Funeral Service L		ett-	Cal	Q	22			s of Facilit		ISA SCO	PF F	UNER	AL H	OME, P.A. D 21078
		+	23a. Part 1. Enter the disease, or	comp	lications that	caused 1	the death.	. Do not ente							<u>arric</u>	<u>,</u>	Approximate
Physician			shock, or heart failure. List o Immediate Cause (Final	nly or	ne cause on e	ne.			X	1	+	-110	ndo				Interval Between Onset and Death
Medica	al	1	disease or condition resulting in death)	r	a. Due to	(or as a	conseque	ence of):			J	Oli	1110			\rightarrow	
Examine		.	Sequentially list conditions,	ı	b. ———											_	
sit sd	Evaminor		if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	4	Due to	(or as a	conseque	ence of):									
be executed sician and burial-transit	2	LYG	that initiated events resulting in death) Last		c. Due to	(or as a	conseque	ence of):									
be exploring special s	<u>.</u>	2		L	d.												
ificate ig phy as the	Modical		IF FEMALE:	1													
h cert tendir r use	11.4	- 1	23b. Was decedent pregnant	1 2	23c. If yes, ou	tcome o	f pregnan	cy death 3 [Ectopic	oregnanc	'Y			115		te of deliv	_
s death	Dhyeician	200	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 ☐ Pre 9 ☐ Unk		time of de	eath 5	Other (sp	ecify)					Mor	nth	Day Year
at the			Part II. Other significant condition	ns co	ntributing to	death bu	t not resul	Iting in the u	nderlying	ause giv	en in Part	l.	23e. Did t	obacco i	use contr	ibute to t	he cause of death?
ires the signs of the sign of the	Š	2	Hyperter	2	100								1 🗆	Yes 2	□No	3 🗆 Pro	bably 4 Unknown
requer shoul	a de la		(The mile		R	o k	-	000					24a. Was	an	24b. V	Nere auto	ppsy findings available
he lav te has age 2	Completed		COMONE			(,,	1	20111	,					ormed?	d	orior to co death? 1 □ Yes	ompletion of cause of
ian: Ti ian: Ti itor, p	B C		25. Was case referred to medical							26. Pla	ace of Dea	th (Checi	1 L Yes	2 X N	0 !	res	2 L NO
hysici nis ce I direc			examiner? 1 Yes 2 No	111	Hospital: 1 □] Inpatie	nt 2 X E	R/Outpatier	t 3 🗆 D	Othe	er: 4 🗆 No	ursing Ho	me 5 🗆 Resi	dence 6	5 🗆 Othe	er (Specifi	y)
ing Pl	ۇ خ	1	27. Manner of Death 1 Natural 5 ☐ Pendin	a	28a. Date (Mor	of injury	Year) 2	28b. Time of injury	2	8c. Injury w <u>or</u> k	? _		28d. Describe f	now injur	y occurre	∌d	
ttend death stor: A	Cortificato.		2 Accident Investig		00- 81	- af laine			M		Yes 2	No					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	٥	5	4 ☐ Homicide determi	ned			(Specify)	ne, farm, stre	et, ractory	, опісе			City or Tov			er or Rura	l Route Number,
spita hours ineral	Modical	2	29a. Certifier 1 Certifying														
the Ho nin 24 the Fu	Mo												the time, date a e, and due to th				ause(s) and manner stated. tated.
To To t			29b. Signature and title of certifier						290	. License	number	17	-/	29d. Da	ite signed	1 (Month,	Day, Year)
		-	Coper	1		1/	-11 /12	20-1 (T	<u></u>			1 /-	20	(20	13	112011
10			30. Name and address of person	C	Smpleted cau			zsa) (Type, F	23	Su	SM	1011	SK	8	161	9	CMI
St Regis	tate	-	31. Date first (Month, Day, Year)	1			's Signatu	re A	back	1							

		-	State Registrar		, , _	Certific	ate of D	Death		i	Reg. No.			
	Physicia	n/	1. Decedent's Name (First, Middle,	•					2	. Date of Dea		Year	3. Time of	
	Medic		Frank John G							Month 8	26 Day	2011	8:24	A M
	Examin	er	4a. Facility Name (if not institution, s Coastal Hospi	,	ako		ity, Town, or Salis		f Death			unty of Death COMic		
1	Funeral				n yrs. last birth		ider 1 Year	If Under 2		. Date of Birtl	1			Foreign
	Director		220-14-9746	1 □XM 2 □ F 8 5	5 Y	rs. Mont	hs Days	Hours	Min. 1	Month Day	1926	Cou	hplace (State or Intry) MD	
	ld now	_	Usual Residence of Decedent 10a. State 10b. County	Ti	0c. City, Town	or Location							10d. Inside Cit	v Limits
	arylar a-f st	ecto		ester	Ocean		7						1X Yes	
	or 28 e not	١	10e. Street and Number	ester	ocean		Zip Code				10g. Citizen	of What Cou	untry?	
	with s 23a lust b	Funeral Director	51 Middle Way	Lane			2184	2			US	A		
	death item		11. Marital Status	12. Was Decedent Eve Armed Forces? 1 ✓ Yes 2 No	er in U.S.	13. Was De If Yes, s	cedent of Hi pecify Cuba	spanic Origi n, Mexican,	in? (Specify Puerto Ric	Yes or No- an, etc.)		Race - Amer Black, White		
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 20 or	d by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1. 丛 Yes 2 ∐ No If Yes, Give Year or Dates.	0	1 □ Ye	s 2 XNo	Specify:			Spe	ecify: whi	ite	
2-0	hour 'natur dical	Completed	15. Decedent	's Education	16a.	l Decedent's l <i>'Give kind of</i>	Jsual Occupa	ation	of working		16b. Kind	of Business I	ndustry	
121	thin 72 ne. than '	mo	Elementary/Seconday (0-12)	College (1-4 or 5+)		ife. DO NOT	use retired)	•	or woming		7		l Comp	2 2 2 2
D D	ed wil Hygie other ent, th	Be	17. Father's Name (First, Middle, La	st)	Sa	les N	lanag		r's Name (F	irst, Middle,			l Comp	any
an	l be fil lental rked ic ev	မ	John F. Lee	,						Ноор		ŕ		
ary	should and N is ma		19a. Informant's Name/Relationshi	p (Type, Print)	19b.	Mailing Add	ress (Street a					vn, State, Zip	Code)	
Σ.	nd 2 s ealth m 27 ner tra		Marilyn Gay	/ Wife				ay La	ane,	Ocean			2184	2
Baltimore, Maryland 21215-0036	Page 1 a ment of H ant: If ite ury or otl		20a. Method of Disposition 1 ☐ Burial 2X Cremation		20b. Place of cemeter)	, crematory	or other plac	e)	Dat			tion - City or		
Ħ	permit. Page 1: Department of I Important: If it any injury or of		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature) Fun Service Lie		First							eral E		_
Ba	permit. Departn Imports any inju	1	W Fun le	2mbale	-					_		MD 2		,
			23a. Part 1. Enter the disease or of shock, or heart failure. List or	complications that aused the	ne death. Do no	ot enter the r	node of dyin	g, such as c	cardiac or n	espiratory arr	est,		Approximate Interval Bety	
- 1	nysician/	2 1	Immediate Cause (Final disease or condition	DAN	RNT	IA							Onset and I	Death
	Medical Examiner		resulting in death)	Due to (or as a c	onsequence of	n:								
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence of	ŋ:								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or impury that initiated events		·									
	tificate be executed ng physician and as the burial-transit	E	resulting in death) Last	Due to (or as a c	consequence o	f):								
3760	ate be	Medical	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	d										
89	± 00 8 ±		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							230	d. Date of del	livery	
Box	e atter	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at ti 9 Unknown			oic pregnand r (specify)	;y				Month		/ear
0	it the c l by th stache	Phy	9 Unknown Part II. Other significant condition		not reculting in	the underly	na couse ai	en in Part I	-	1000 Did to	h aa aa u aa	contribute to	the cause of d	eath?
ν, Τ.	res tha signed	d by	Fart II. Other Significant Condition	is contributing to death but	not resulting if	Title dilderly	ng cadoc gn	on mir arti.		1 🗆	-	,	robably 4	
ğ	requi been should	Completed								24a. Was	an 2		topsy findings a	
Š •	he law te has age 2	omp								autop perfo 1 Yes	rmed? 2 \(\sum \) No	death?	completion of c	ause of
<u>a</u>	ian: T rtifica stor, p	Be C	25. Was case referred to medical examiner?				26. Pl	ace of Deatl	h (Check o		Z L NO	1 163	2 45 110	
5	hysic his ce Il direc	မ	1 ☐ Yes 2 No		t 2 🗆 ER/Out		_	4					ity) HOSPIC	cre_
Division of Vital Records,	Jing P h. After t funera	Certificate:	27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day,)	Year) 28b. Ti	me of jury M	28c. Injun work	yat ? Yes 2 🗆		d. Describe h	ow injury oc	curred		
SIO	Atten r deat ctor; by the	rtific	2 Accident Investigation 3 Suicide 6 Could not determine the second seco	ot be 28e. Place of Injury				ies Z		f. Location (S	treet and N	umber or Ru	ral Route Numb	per,
<u>≥</u>	tal or rs afte al Dire ed in t		4 D Horricide determin	building, etc. ((Specify)					City or Tow	n, State)			
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death so. To the Euneral Director; After this certificate has been signed by the attendir completed filled in by the funeral director, page 2 should be detached for use	edical	(Check 2 Medical Ex	Physician: To the best of my	mination and/or	investigation	, in my opinic	on, death oc	curred at th	e time, date a	nd place, an	d due to the	cause(s) and ma	nner stated.
	o the	Š	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: To the be	est of my knowle		ccurred at the 29c, License	_	and place,			nd manner as		
	F>F0						De	05-5	3411				2011	
			30. Name and address of person w	ho completed cause of dea	th (Item 23a) (T	ype, Print)								
	8+1 £	T	CHULAM WI	my po	1300	173	13 5	AUS	Bur	f in	2	1804		
	Stat Registra	e ir	31. Date filed (Month, Day, Year) AUG 30	2011 32/Registrar's	s Signature	park	1		J					

			for State Registrar	State of Maryla	•	artment of F tificate of L			lene leg. No.		
	Physicia		Decedent's Name (First, Middle, Last) HARRY LEE HARM	JER				2. Date of Dear Month AUGUST		(ear	3. Time of Death 7:15 P M
	Medic Examin		4a. Facility Name (if not institution, give st	reet and number)	OCDICE	4b. City, Town, o	r Location of Death		4c. County of MONTG		
امري	Funeral		CASEY HOUSE MON 5. Social Security Number 6. Sex		:. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
	Director		214-32-9277 1	M 2 □ F 76	Yrs.	Months Days	Hours Min.	01/10/	1935	Count	MD MD
	yland -f show ied at	ctor	10a. State 10b. County		OYDS	cation				10	0d. Inside City Limits
	the Mar or 28a	Director	MD MONTGON 10e. Street and Number	TEKI DO	0105	10f. Zip Code			10g. Citizen of Wh	nat Count	
	ath with ms 23a must b	Funeral	21615 SLIDELL F	ROAD	16 12 1	208		ooih, You or No	US	-	- to die
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fi	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		f Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	14. Race Black,	White, e	etc.
215-(n 72 hor e. an "nat Medica	mple	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)	cation e com <i>pleted)</i> College (1-4 or 5+)	(Give I	lent's Usual Occup kind of work done o O NOT use retired)	pation during most of work	king	16b. Kind of Bus		•
121	ad withir Hygiene other th	Be Co	10 17. Father's Name (First, Middle, Last)	College (1-4 of 5+)	ESTI	MATOR /	PLANNE	R ne (First, Middle, M	WE.	APOL	
Maryland	ld be filed Mental Hy arked oth atic event	은	CHARLES JACOB I	HARNER					E LARM.	AN	
	nd 2 should ealth and Me m 27 is mar her traumati		19a. Informant's Name/Relationship (Type DORIS HARNER /				and Number or Rui				ode)
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	lemoval from State B	OYDS P	sition (Name of natory or other plac RESBYTE CEMETED	RIAN 08	Date /30/201	20c. Location - C		
Ba	permit Depar Impor any in		21. Signature of Fane al Struce Licensee		22	. Name and Addre		P. HOME BA	O. BOX	86 LLE	, MD
ì			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the de cause on each line.							Approximate Interval Between Onset and Death
- 4	Medical		Immediate Cause (Final disease or condition resulting in death)	PROSTATE Due to (or as a conse		R				-17	Onset and Death
	Examiner	er	Sequentially list conditions, bif any, leading to immediate	Due to (or as a conse	oguence off:						
	cuted nd ransit	camin	cause. Enter Underlying Cause (Disease or imjury that initiated events								-
0	cate be executed physician and the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a conse	equence of):						
68760	rtificate ing phys e as the		IF FEMALE:								
Division of Vital Records, P.O. Box 6	ne death certificate be executed the attending physician and ched for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	8c. If yes, outcome of preging 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnand Other (specify)	cy		23d. Date Mont		Pry Day Year
s, P.O	To the Hospital or Attending Physician: The law requires that the de within 24 hours affart death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	þ	Part II. Other significant conditions conf	tributing to death but not r	esulting in the u	nderlying cause gi	ven in Part I.				e cause of death?
scord	S 8 0	Completed						24a. Was a autops perfor	sy pr	ere autop or to cor ath?	osy findings available mpletion of cause of
al Re	ian: The rtificate stor, pag	Be Co	25. Was case referred to medical			26. Pl	lace of Death (Chec	1 Tyes		Yes	2 No
f Vit	Physical this ceral direction	유	examiner? 1 Yes 2 No 27. Manger of Death	ospital: 1	ER/Outpatien	oth	4 ☐ Nursing H				HOSPICE
ou o	ending eath. or: After he fune	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year)	injury	work		28d. Describe no	ow injury occurred		
Divisi	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rural	Route Number,
	e Hospi 1 24 hou e Funer	Medical	(Check 2 Medical Examine	ian: To the best of my knoer: On the basis of examinat Practioner: To the best of	ion and/or invest	tigation, in my opinio	on, death occurred a	at the time, date ar	nd place, and due t	o the cau	use(s) and manner stated
	To th Withir To th COMP	~	29b. Signature and title of certifier	Vicel.	(0	29c. License	e number		29d. Date signed		
	5		30. Name and address of person who cor	npleted cause of death (Ite	em 23a) (Type, P		3201		8/2-	///	1
			DEBRAH MILLER	, CRNP 600	1 MUNC		IILL RD.	, ROCK	/ILLE,	MD :	20855
	Stat Registra	e ar	31. Date filed (Month, Day, Year) AUG 2.9 201	32 Registrar's Sign	D. Jose	arles					

29540

Physician/
Medical
Examiner

Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

For State Registrar		State of Ivia	aryiand / Dep Cei	artificate of D			g. No.		
	ne (First, Middle, Las	st)				2. Date of Death		Vear	3. Time of Death
	<u>rie Hewit</u>					August	24	2011	3:30P ^M
	f not institution, give	,		4b. City, Town, or I				unty of Death	
4920 CI	overdale lumber 6. Se		(In yrs. last birthday)	LaPla If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	LI	1	olace (State or Foreign
085-54-8 Usual Residence of	955	□ M 2 🔀 F	56 Yrs.	Months Days	Hours Min.	3/18/19	55	Jama	ica
10a. State	10b. County		10c. City, Town or Lo					1	0d. Inside City Limits
MD	Charles		LaPlata	a					1XXYes 2 □ No
10e. Street and Nu	mber			10f. Zip Code		10	_	of What Coun	itry?
	<u>overdale</u>			20646				SA	
11. Marital Status 1 Never Mari 3 Widowed	ried 2 X Married	12. Was Decedent E Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates.	No I	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🕱 No		ecity Yes or No- Rican, etc.)		Race - Americ Black, White, e ecify: Blac	etc.
/Sne	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	tion	vina .	16b. Kind	of Business Inc	dustry
1 Never Mari	1	College (1-4 or 5-	life [kind of work done du OO NOT use retired)		ang	TA		
	(First Middle (see)	2		EX. Secre			IN		
17. Father's Name					18. Mother's Nan Semie	ne (First, Middle, M. Nanhne	aiden Suri	name)	
	ame/Relationship (7)	ivpe, Print)		ing Address (Street ar	nd Number or Rui	ral Route Number, (Code)
Godfre	y Hewitt/	Husband	4920	Cloverdal	e Court	LaPlata,	MD 2	20646	
	•	Removal from State	20b. Place of Dispo cemetery, cre Huntt Cre	matory or other place		Date 2		ion - City or To lorf,M	
21. Signature of Fu	Ineral Service Licens		2	2. Name and Address 035 01d W	of Facility	untt Fun	eral	Home	
	art failure. List only o (Final on	plications that caused ne cause on each line a. CAR		ter the mode of dying	, such as cardiac	or respiratory arres	st,/		Approximate Interval Between Onset and Death
Sequentially list co	onditions,	b. A	DRIAM consequence of):	YCIN		1. /		73	
cause. Enter Unde Cause (Disease or that initiated event resulting in death)	iinjury ts	c. Due to (or as a	consequence of):		CERTIFICATIO	NAPPROVED BY ME	DICAL EXA	MINER	
	•	d			//				
IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	menths? No	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal death 3	Contraction of the contraction o	, //		230	l. Date of deliv Month	ery Day Year
		ontributing to death bu			en in Part I.	23e. Did tob			he cause of death?
		•				24a. Was an autops	y 2	24b. Were auto	psy findings available empletion of cause of
25. Was case refer	red to medical			00.01	no of Death (Ot	1 \(\text{Yes} \) 2	No	1 Yes	2 No
examiner?		Hospital:	ent 2 🗆 ER/Outpatie	Othe	ce of Death (Chec	lome 5 Reside	200	Othor /5	4
27. Manner of Deat		28a. Date of Injur (Month, Day	y 28b. Time o	of 28c. Injury work?	at	28d. Describe ho			<i>(</i>)
3 Suicide 4 Homicide	6 Could not be determined	ne -	ry - At home, farm, st . (Specify)			28f. Location (Str City or Town		umber or Rura	I Route Number,
(Check	2 Medical Exam	sician: To the best of iner: On the basis of exserving Practioner: To the l	kamination and/or inves	stigation, in my opinio	n, death occurred	at the time, date and	d place, an	d due to the ca	iuse(s) and manner sta
29b. Signature and	Aitle of certifier	Je Jean)	29c. License	number 2 60	64	9d. Date s	igned (Month, \$-2-6	Day, Year) - 2-0
30. Name and add	ress of person who	completed cause of de		Print) 10	583-T	HEODO	RE	GREE	2011 20 BLV 20695
31. Date filed (Mon	th, Day, Year)	32. Registra	r's Signature	hords!		U	-, -		

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29541 State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aug 20, 2011 Physician/ Francis Joseph 8:15 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Linthicum Chesapeak Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Aug 17, 1918 Washington DC Director 93 579 07 8296 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 28a-f 1 ☐ Yes 2 🛣 No Maryland Edgewater Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò by Funeral 23a United States 21037 3264 Landing Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked Attachment any injury or Attachment. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Yes 2XXNo 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 I.B.E.W. Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elsie Zeller John J. Healy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Huttenloch (Daughter) 4703 Mellwood Road, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Aug 27, 2011 Silver Spring, MD Gate of Heaven 21. Signatury of Fune al Service Livensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MD 20735 Ferry Road Clinton. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to for as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 3 Probably 4 Unknown No Completed Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Natural work?
1 Yes 2 No iniury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of co

LOS

State Registrar erson who completed cause of death (Item 23a) (Type, Print)

2011 23342

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE PATRICIA HOWARD Physician/ 2011 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. (Month, Day, **28** 1 □ M 2 🖺 F Trinidad Director 580-14-1079 Ĩ′951 Usual Residence of Decedent ural", or items 23a or 28a-f shov I Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No MD Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 12814 Crisfield Road 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1X Never Married 2 ☐ Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: Afro-Amer. 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Asst. Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Rudolph W. Howard Millicent Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlyle Howard / Brother P.O. Box 10161, St. Thomas, Virgin Islands 00801 20b. Place of Disposition (Name of Chesaneakery or other place) Crematory Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/30/11 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Washington, D.C. 20012 21. Signature of Funeral Service License 22. Name and Address of Facility Thom #cGuire Funeral Service, 7400 Georgia Ave.NW 23a. Part 1. Enter the disease, or complications lost caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysiciani disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transity. attending physician and I for use as the burial transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 2 🗌 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ၉ 1 🗌 Yes 1- Inpatient 2 ER/Outpatient 3 DOA Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certiful 29d. Date signed (Month, Day, Year) 00064024 7600 Carroll Ave. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D LACHTCHININA Takoma Park, MD 20912 TANNA 31. Date filed (Me State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 26^{Day} 2011 Year Month AUG 2:53 Physician/ TAMMIE T. HOLMES Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** MONTGOMERY BETHESDA CENTER NATIONAL NAVAL MEDICAL 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Country) Days Hours 1 🗆 M 2 🔀 Virginia Director 224-90-0610 53 Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County Director 1 X Yes 2 No Gaithersburg MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe . Page 1 and 2 should be filed within 72 hours after death with is trent of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a jury or other traumatic event, the Medical Examiner must b. Completed by Funeral U.S.A 20877 2 Briarstone Lane 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give 20 yrs **B**Lack 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Sargeant First Class U.S. Army Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Freda Daniels Harold Holmes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gaithersburg, MD 20877 Myown T. Holmes/daughter 20a. Method of Disposition Briarstone Lane 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 s Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 10/6/2011 Arlington, VA 4 Donation 5 Other (Specify) Arlington Nat'l Cem 22. Name and Address of Facility Snowden Funeral Home P.A. 21. Signature of Funeral Service Licen X e 200E Mouda 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ CIRRHOSIS OF THE LIVER disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner MESENTERIC ISCHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury DISSEMINATED INTRAVASCULAR COAGULATION Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-ray that initiated events resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Day Month in the past 12 months?

1 Yes 2 No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy After this certificate has performed? 1 Yes Yes 2X No 26. Place of Death (Check only one, Be Division of Vital 25. Was case referred to medica examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 A Inpatient 2 ER/Outpatient 3 DOA 2 No မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 24 hours after death.

Funeral Director: Aft leted filled in by the fur 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29d. Date signed (Month, Day, Year) 0 0 mo AUG 26 2011 DD43443 NATIONAL NAVAL MEDICAL CENTER and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 John Chandler 2. Registrar's Stgn ure State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 201 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Physician/ 2011 1:15 P M Leah Wrenn Hillock Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Atlantic General Hospital Berlin Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 1 🗆 M 2 🔯 F Director 220-56-6097 60 MD Usual Residence of Decedent 28a-f show 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🙀 No MD Anne Arundel Pasadena ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 233 Armstrong Lane 21122 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 X Married þ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Spring Grove Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Hospital Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) T. Randal Wrenn Almeda M[©]Murrav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Don N. Hillock/husband Armstrong Lane, Pasadena, MD 21122 Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or 8/23/2011 Millsboro, DE First State Crem. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Servic Acensee 21. Signatu 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying e attending physicia.... Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 2 No ed by the a detached f 9 Unknown 9 Unknown Division of Vital Records, P.6. within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Winknown comeen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe Yes 2 death? Hospital or Attending Physician: The 124 hours after death.

Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work? 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 0064/20 and address of person who completed cause of death (Item 23a) (Type, Print) 27/12 Hoelth Way Drive Berlin

State Registrar

220

9733

Aau

		1 - State Registrar		Cen	tificate of E	Death		Reg. No	o	
Physicia Media		1. Decedent's Name (First, Middle, Last) William R. Hoeni	-g				2. Date of De	eath 25 ^{Da}	ay 20 1 °1	3. Time of Death 11:12P м
Examir		4a. Facility Name (if not institution, give stree Atlantic Gerneral			•	Location of Death			c. County of Death	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		Berlin If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	g. Birth	place (State or Foreign ptry)
Director		149-24-3214 Usual Residence of Decedent	77	Yrs.			6/23/	193	4 100	
Maryland 28a-f shov otified at	Funeral Director	10a. State 10b. County Worceste		Town or Loc	ation			_		10d. Inside City Limits
with the s 23a or ust be n	eral D	10e. Street and Number 7 Long Point Cot	ırt		10f. Zip Code 21811				itizen of What Cou SA	untry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 🛣 Married	Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.	If	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 XNo	ispanic Origin? (Spin, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: Wh	
thin 72 hounder.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Seconday (0-12)		(Give ki life. DC	NOT use retired)	ation during most of work	ing	1	Kind of Business I anning	ndustry
direction of filed with the filed with the feed other covent, the covent, the feed other covents of	To Be C	17. Father's Name (First, Middle, Last) unknown	2	Own	er	18. Mother's Nam				
12 should buth and Me 27 is mark		19a. Informant's Name/Relationship (Type, I Barbara Hoenig/W	,	19b. Mailing	g Address (Street a	and Number or Run	al Route Numbe	er, City o	r Town, State, Zip ID 2181	Code)
Page 1 and nent of Healurt: If item ry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	20b. Planoval from State	ace of Dispos emetery, crem	sition (Name of atory or other place ate Cre	re)	Date	20c. L	ocation - City or	Town, State
permit. Permit	3	21. Signature Fureral Service Licensee	n	22.	Name and Addres	-			William	
Physician/		23a. Part 1 Enter the disease, or complicat shook, or feart failure. List only one call mmediate Cause (Final disease or condition	ions that caused the death use on each line. Refroper Due to (or as a conseque	. Do not enter	r the mode of dyin	g, such as cardiac	or respiratory a		eriin M	Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):			,			
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c	Due to (or as a conseque	ence of):						
rate be executed physician and the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a conseque	ence of):						
tificate ng phy as th	Med	IF FEMALE:						Т		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de g ☐ Unknown	death 3 🗌	Ectopic pregnand Other (specify)	y .			23d. Date of deli Month	very Day Year
requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contrib	outing to death but not resu	llting in the ur	nderlying cause giv	ven in Part I.				the cause of death?
The law requirate has been page 2 shoul	Completed						24a. Was auto perfe 1 \(\sum \) Yes	psy	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
an; Th tifficat tor, pa	Be C	25. Was case referred to medical			26. Pl	ace of Death (Chec		2 Ø N	lo <u>l 1 ⊔ Yes</u>	2 No
hysici hls cer I direc	To E	examiner? 1 Yes 2 No Hosp	1 Inpatient 2 🗆 E		3 DOA Othe	er: 4 Nursing Ho	ome 5 🗆 Resi	idence	6 ☐ Other (Speci	fy)
ending Path.	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 \square	∕at ? Yes 2 □ No	28d. Describe	how inju	ry occurred	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.		3	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (City or To		nd Number or Rur e)	al Route Number,
ne Hosp In 24 hou ne Funei pleted fil	Medical	(Check 2 Medical Examiner:	n: To the best of my knowle On the basis of examination actioner: To the best of my	and/or investi	gation, in my opinio	on, death occurred a	t the time, date	and place	e, and due to the o	ause(s) and manner stated
To the To the Common	_	29b. Signature and title of certifier			29c. License	64/20		29d. Da	ate signed (Month)	, Day, Year)
BA 9+1		30. Name and address of person who comp Att Zees han Da	H 9733 Ha	23a) (Type, Pralth U	int)	ve Be	rling	un	al sl	1.
Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 201		ire de	med		•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 8 Physician/ Month Robert Householder Jerry September 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Meritus Medical Center Washington Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours Aug. 30, 1 X M 2 D F 045-32-2443 Director 1945 Connecticut 66 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 💢 No WV Berkeley Falling Waters 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 148 Alamo Lane 25419 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: should be filed within 72 hours aft, and Mental Hygiene.

is marked other than "natural", Specify: 3 Widowed 4X Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Gladys Tomatore Raymond Householder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CT06606 Lorraine Pereira/Sister 121 Martha Place, Bridgeport, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Smithsburg, MD Smithsburg Crematory 9/10/ 2011 Rest Haven Funeral Chapel 21. Signature of Funeral Service Lice 22. Name and Address of Facility 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one cae ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ irrhosis of disease or condition ears Medical resulting in death) Due to (or as a consequence of Examiner Hepatitis YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and -transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Veal Pregnant at time of death been signed by the should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown renal failure Were autopsy findings available prior to completion of cause of death? 24a. Was an diabetes mellitus has je 2 autopsy page this certificate 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 🗌 Yes မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: of the funeral Director. 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) Cynthia Kutther Sands no D4745 September 9, 2011

State

Registrar

31. Date filed (Month, Da

1 5 2011

747 Northern Avenue

Hagerstown, Maryland 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington County, Cynthia Kuthner-Sands, no Hospice of Washington County

32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Randy Keith Jones September 6:50 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 30240 Cochise Ct. Mary's Mechanicsville 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under If Under 24 Hrs **Funeral** 1 **X** M 2 □ F Months (Month, Day, Year Hours **Director** 03-16-1956 313-60-4262 55 Indiana Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a State 10b. County must be notified at 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Tes 2 X No St. Mary's **Mechanicsville** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 30240 Cochise Ct 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 \(\square\) No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: "natural", 3 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Defense Contractor Systems Engineer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Mildred Welch Harold Bussey Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traunonce. 30240 Cochise Ct., Mechanicsville, MD 20659 Amelia Kay Jones/Wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Brinsfield-EcholsCrem. 09/08/2011 Charlotte Hall, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signature of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5) pmu Moakley 5+. 20650 23130 Leonard ma 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 29548 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 2011 Howard Earl JOHNSON 9;37 p. M Sept. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 827 Noland Drive Hagerstown Washington Social Security Number Age (In yrs. last birthday 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Feb. 11,1940 **Director** 71 220-34-0169 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 23a or 28a-f shust be notified 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? Funeral 827 Noland Drive 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter Armed Forces?

1 Type Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify white 3 Widowed 4 Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) machinist trucking mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ≠1 and , of of Health an, '* item 27 is marx, '* traumatic ev ပ္ Howard Lee Johnson Carrie Amelia Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Johnson - wife 827 Noland Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important; If it any injury or o 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar Lawn Mem. Park 9/6/2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Chronic obstructive 12ars Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Directo (or as a consequence of) Exami Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cancer of the tongue 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown congestive heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No or Attending Physician; after death. **Director:** After this certific I in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending injury 2 Accident
3 Suicide
4 Homicide M 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Kuttree Sards, no September 4, 2011 D0047451

DHMH 17 Rev 7/2009

State Registrar

centha

31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eyn thia Kuther Sands, me Hospice of Washington County,

32. Registrar's Signature

11-06379 Kerry Kelpy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 29549

		1- For State Registrar		Certifica	te of De	ath		-	Reg. No.		
Physic		Decedent's Name (First, Middle,t	ast)					2. Date of De Month		Year	3. Time of Death
edical Examالم	iner		Kerry Byron	Kelpy,				August 2	24, 2011		1423 hrs
Parks		4a. Facility Name (if not institution, 4415 Ed McClain Road	give street and number)			ty, Town, or Lo onrovia	ocation of De	eath	i	ounty of Deat derick	h
Funeral		Social Security Number 6.	Sex 7. Age (In	yrs. last birth		Inder 1 Year	If Under 24		Birth (MM/DD	YYYY) 9. Bi	rthplace (State or
Director		217-42-1417 Usual Residence of Decedent	M 2 F	67	Yrs. Mo	onths Days	Hours N	July	27,19	44	gn buntry) Washingto D.C.
*up		10a. State 10b. County	10c	c. City, Town o	r Location						10d. Inside City Limits
* .	_	Maryland Fre	derick			Monroy	หรือ				1 Yes 2 No
urylan Sa-f s	왕	10e. Street and Number	derick		10f.	Zip Code	via		10g. Citizen	of What Cou	Intry?
n the Mi 3a or 2	Director	4415 Ed	McLain Road			21	1770			USA	
5-0036 Jed within 72 hours after death with the Maryland Sygene. The than "natural", or items 23a or 23a-f show the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married	ed 12. Was Decedent Eve Armed Forces? 1 Yes 2					(Specify Yes or Nerto Rican, etc.)	lo- 14.	Race - Ame White, etc.	rican Indian, Black,
fter d ", or		3 Widowed 4 Divorce	ed If Yes, Give Year	No	1 Yes	2 X No	specify:		Spe	ecify:	White
15-0036 filed within 72 hours after 1 Hygiene, ed other than "natural", o t, the Medical Examber 1	d by	15. Decedent's Education (Specify	only highest grade complet			ual Occupatio			16b. Kind	of Business	
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	du	uring most of	working life. D	OO NOT use	retired)			
036 ithin ne. r tha	ם		4		\mathbf{T}	eacher			Cot	ınty G	overnment
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, La	st)	•		18	3.Mother's Na	me (First, Middle	, Maiden Sur	name)	
21215 vuld be fil Mental H marked	Be	Larner W. Kelpy						Krebeck	L J.		
hould Male is my	은	19a. Informant's Name/Relationship		100	-	•		or Rural Route No			
MD 2 sho alth and in 27 is		Karen A. Kelpy, 20a. Method of Disposition	Wife	20b. Place of	415 Ed	McLair	n Road	, Monrov	ia, M) 2177	Or Town, State
imore, MD 2121 Pages I and 2 should be fit nent of Health and Mental sant: If item 27 is marked or other traumatic event,		1 Burial 2 Cremation		cremator	ry or other pla	ce)	etery,	Date	20C. LOC	ation - City of	Town, State
Page nent o		4 Donation 5 Other Spec		Cren	Metrop natori	um, Ind	a. Au	g.31,201	1 Alex	kandri	a, Virginia
Baltimore, MD ; permit. Pages 1 and 2 shot Department of Health and Important: If item 27 is injury or other traumatic		21. Signature of Funeral Service Mo		.Ksl	22 Name a	and Address o	of Facility	ams, P.A , Damasc			
Physician		23a. Part I. Enter the disease, or co									Approximate Interval
∜Medical		failure. List only one cause on Immediate Cause (Final disease	a. Torso Injuries								Between Onset and Death
≛xaminer	ĺ	or condition resulting in death)	Due to (or as a conseque	ence of):	_						
		Sequentially list conditions,	b								
	ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	ence of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):							-
uted nd ransit		overtion researching in additing Education	d.								
exectian artial - t	<u> 2</u>	UNPENDED	AMENDED								
760, icate be executed g physician and the burial - transit	Medical	IF FEMALE:	23c. If yes, outcome of	f pregnancy					23d. D	ate of deliver	<u>1</u> y
Box 68760, i death certificate be attending physical for use as the but	ician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 [Fetal dea	ath 3	Ectopic pre	gnancy	Mo	onth	Day Year
Box 687 ne death certifi. The attending	sici	1 Yes 2 No 9 Unkno		of death 5	Other (S	Specify)			1		
the de shed f	Physi	Part II. Other significant condition		t not resulting	in the underly	ina cause aiv	on in Part I	23e Did	tobacco use	contribute to	the cause of death?
ires that the signed by	þ	Ture in Other organization	s contributing to death but	t flot resulting	iii tile dilderi	mig cause giv	on in rait i.				bably 4 Unknown
ision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certif r death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as											utopsy findings available
of Vital Records, ag Physician: The law require the true conficue has been simeral director, page 2 should be	Completed							_ auto	opsy	prior to	completion of cause of
Rec The la	팅								formed? 2 No	death? 1 ✔ Y	es 2 No
Vital Reconstituted The lateral The lateral Information in the lateral Info	B B	25. Was case referred to medical examiner?					f Death (Che	ck only one)			
Vit hysical this o		1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Out	patient 3	DOA O	ther ₄ Nur	rsing Home 5	Residence	6 🗸 Othe	r: Scene
n of V		27. Manner of Death	28a. Date of Injury FOUND:		me of Injury	28c. Injury		28d. Describe Subject inj			chainsaw
ion trendi leath. tor:	[읉	1 Natural 5 Pending 2 ✓ Accident Investig	Aum 04 0044	1400		1 Ye	s 2 🗸 No	Gubjoot III,	aroa min	, doing a	SHAIN CAN
Division tall or Attending a strength.	[발	3 Suicide 6 Could n	ot be 28e. Place of Injury	- At home, farr	m, street, fact	ory, office bui	Iding, etc.				ural Route Number, City
Division pltal or Attentours after death neral Director: filled in by the	Certification	4 Homicide determine	(Specify) Yard					or Town, 4415 Ed Mc	Clain Road	, Monrovia,	MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical (29a. Certifier (Check only one) 2 Medical Examin	ician: To the best of my knowner:On the basis of examination	owledge, death	h occurred at vestigation, in	the time, date	and place, a death occurre	and due to the car ed at the time, dat	use(s) and m e and place,	anner as sta	ted ne cause(s)
To To con	Ş Ş	29b. Signature and title of certifier	and manner stated.			29c. License i					onth, Day, Year)
		1 1 2				O.C.M	.E.		1	t 25, 2011	
1		20 Name and address ((lkem- OC)		J.J.,W					
8		30. Name and address of person &r Ling Li, MD Assistant	o completed cause of death Medical Examiner		ltimore St	reet Baltin	nore MD	21223			
			32. Registrar's Si		-						
S Regis	tate trar	31. Date filed (Month, Day, Year)	1011 Senson	1.	parke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29550 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ igust Medical Examiner 4c. County of Death Itimore 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 69 142-32-3795 1 🗆 M 2 🕱 F 27, New York Director Yrs Aug. show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Anne Arundel Annapolis 28a-f XXYes 2 ☐ No 10g. Citizen of What Country? ō 10e. Street and Number 10f. Zip Code 23a Funeral 1949 Fairfax Road 21401 U.S.A. ural", or items? death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 XX Married 1 Yes Page 1 and 2 should be filed within 72 hours after 2 X No Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. White Specify: id Mental Hygiene. marked other than "natural", 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Senior Citizens Teacher Teaching Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles J. Flemke Attilia Oliveri and i 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8242 Quarterfield Road Severn, Maryland 2 19a. Informant's Name/Relationship (Type, Print) Anthony Charles Lloyd/son 21144 item 27 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 1XXBurial 2 Cremation 3 Removal from State Hillcrest Mem. Gardens 8/31/2011 Annapolis, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 000 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final Julmonar Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 No cate has page 2 s 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury Accident Investigation Suicide 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Toleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title.

Registrar

State

31. Date filed

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ A<u>ugust</u> Eleanore Ann Levanduski 2011 2:30P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis of Waldorf Waldorf Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral (Month, Day, Days 1 🗆 M 2 🗶 F Months Hours Min South Carolina **Director** 214-72-3253 Jan Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location notified at Director 1 Yes 2 No Maryland Waldorf Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ural", or items 23a or Examiner must be Funeral 5200 Lamprey Court USA 20603 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. "natural", White Completed 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis Levanduski Rita Salva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 5200 Lamprey Ct. <u>Waldorf, Maryland 20603</u> Rita Levanduski/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Waldorf, MD Huntt Crematorv Aug. 30. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, shock, or heart failure. List only on cause of each line. such as cardiac or respiratory arrest, Approximate Interval Between each line. Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or a a consequence, of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? sate has been signed l page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ Nursing Home 5 Residence 6 Other (Specify 1 🗌 Inpatient 2 🗍 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 \square Pending work?
1 Yes 2 No within 24 hours at er death.

To the Funeral Director A Accident Investigation 3 - Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature an (Month, Day se of death (Item 23: 2860 72B2

Registrar

State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		For State Of IVIA State Registrar	ryland / Depa <i>Cen</i>	tificate of De		Reg.	2011	29552
Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Dav Year	3. Time of Death
Medic Examin	al	Mary Mildred Lawhorn 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ocation of Death	September	4c. County of Dear	
Examin	er	36874 West Lakeland Drive		Mechani			St. Ma	
Funeral		1 M 2 🗶 F	(In yrs. last birthday)		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 10-24-19	9. Bir (r) Co	thplace (State or Foreign buntry)
Director		577-24-1890 Usual Residence of Decedent	89 Yrs.			10-24-192	21 Vi ₁	rginia
land show d at	tor	10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
Mary 28a-f otifie	Director	Maryland St. Mary's	Mechanic					1 Tes 2 X No
th the 3a or t be n		10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	,
ath wi ems 2 r mus	Funeral	36874 West Lakeland Drive 11. Marital Status 12. Was Decedent Ev	rer in U.S. 13. W	20659 /as Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spec	cify Yes or No-	U S A	
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎛 Divorced Armed Forces? 1 ☐ Yes 2 🖼 N If Yes, Give Year or Dates.		Yes, specify Cuban, ☐ Yes 2 ※ No		Rican, etc.)	Black, Whit	•
5-0 2 hour	Completed	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupati		ng 16b	. Kind of Business	Industry
121 thin 7; ene. than	Som	Elementary/Seconday (0-12) College (1-4 or 5-)	NOT use retired)			Food Ser	vice
d 2 ed wii Hygie other ent, tt	Be (17. Father's Name (First, Middle, Last)	Ca	feteria W	-	(First, Middle, Maid		VICE
land libe filed fental Hyg rked oth	2	William Rutherford			Minnie	Pearson		
Marylanc 12 should be file 1th and Mental I 27 is marked o		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and	d Number or Rura	Route Number, City	or Town, State, Z	ip Code)
e, M and 2 s Health tem 27 other tra		Tamara Maples/Granddaughte						, MD 20659
Baltimore, Maryla permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic.		20a. Method of Disposition 1	1	atory or other place)	İ		. Location - City o	
Itin		4 ☐ Donation 5 ☐ Other (Specify) 21. Si Jeffre of Funeral Service Licensee	Marshall C	em. Assn. Name and Address		3/2011 Ma		
Balti permit. I Departm Importa any inju		Charte (Establish	and the same of th					1, MD 20622
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.			such as cardiac o	r respiratory arrest,		Approximate Interval Between
Physician/		Immediate Cause (Final disease or condition	one K	dney	Disea	se		Onset and Death
Medical Examiner		resulting in death) Due to (or as a	consequence of):	/				
	Jer	Sequentially list conditions, b.	consequence on:					
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	AD					
760 cate be executed physician and sthe burial-transit		resulting in death) Last Due to (or as a	consequence of):	-				
760 cate be physici	edical	d	/ement	11/	_			
		IF FEMALE: 23c. If yes, outcome of	f pregnancy				23d. Date of de	eliven
ivision of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certificate death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Physician/N	in the past 12 months? 1 Vex. 2 No. 4 Pregnant at	Fetal death 3	Ectopic pregnancy Other (specify)			Month Month	Day Year
P.O. BOX that the death or ned by the atter e detached for u	hys	g Tunknown 9 🗆 Onknown			<u>-</u>			
ords, P.O. Be requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but the part of th	t not resulting in the u	nderlying cause giver	n in Part I.	0	. /	o the cause of death? Probably 4 Unknown
rds equire	sted	700000	1101-11	14, 19				
Records, The law requires cate has been sig	Completed			r		24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
/ital Recc rsician: The law s certificate has l lirector, page 2 s		25. Was case referred to medical		26 Plac	e of Death (Check	1 ☐ Yes 2 ✔	No 1 Ye	es 2 No
Vita vsicia s certi directo	To Be	examiner?	nt 2 ER/Outpatien	Other	,	me 5 Residence	e 6 Other (Spe	ecify)
of V ng Phys ter this neral di		27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of injur (Month, Day,	28b. Time of	28c. Injury a work?		28d. Describe how in		
ion tendir leath. or: Af the fu	Certificate:	2 Accident Investigation		M 1 □ Y∈	es 2 🗆 No			
Division of Vital ral or Attending Physician: staffer death. al Director. After this certification by the funeral director.	Cert	4 Homicide determined 28e. Place of Injurbuilding, etc.	y - At home, farm, stre (Specify)	et, factory, office		28f. Location (Street City or Town, St	t and Number or R tate)	ural Route Number,
Spital hours neral		29a. Certifier 1 Certifying Physician: To the best of r						
Division of V To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director. After this completed filled in by the funeral d	Medical	(Check 2 Medical Examiner: On the basis of exonly one) 3 Certifying Nurse Practioner: To the basis of exonly one)	amination and/or invest sest of my knowledge, o	igation, in my opinion, leath occurred at the t	death occurred at ime, date and place	e, and due to the cau	use(s) and manner a	s stated.
To t with To t		29b. Signature and title of certifier	_	29c. License n	1 mumber	7 29d.	Date signed (Mon	th, Day, Year)
		- CXIVE	L	1/3	7100	<i>T</i>	1-9	-2011
Jerne		30. Name and address of person who completed cause of de Manoj Panwala, M.D. 37767			otte Hal	1. MD 206	22	
Sta	te	31. Date filed (Month, Day, Year) 32 Registral	's Signature	· ·· J	orre nat	<u> </u>		
Registr	ar	SEP 0 9 2011	D. 194					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TE Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GENESIS CRESCENT UTIES KIVERDAVE PG COUN Social Security Number 8. Date of Birth (Month, Day, Year) April6,1932 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 😾 F Months Days Min. Hours New York 248-44-7431 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if fire 27 is marked other than "natural", or items 23a or 28a-f sho Important if fire 27 is marked other than "natural", or items be notified at The Maryland or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ¥ Yes 2 ☐ No Prince George's Bladensburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Apt.201 20710 5201 Quincy St. U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 🖾 Divorced Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Marriott Inflight College (1-4 or 5+) Elementary/Seconday (0-12) Utensil Preparation Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5201 Quincy St. Apt. 201 Bladensburg, Md. 20710 Butler (Daughter) Audrey 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chambers Crematory Riverdale, Md. Aug.31,2011 ²² Name and Address of Facility Chambers Funeral Home & Crematorium, P.A 5801 Cleveland Ave. Riverdale, Md. 20737 21. Signature of Funeral Service Licenses Momas am 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lin Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death TROK ∉nysician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician. The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live Birth 2 Fetal death
4 Pregnant at time of death Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 No Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate Yes 2 director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? ဂ္ 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directorial directors and the funeral directors. Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: An the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00064208

Registrar

State

Saadia

31. Date filed (Month, Day, Year)

AUG 31

EAST

WEST HWY RIVERDALE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4409

Husain

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Augus T horb jorn 12:40 AM -arsen 1105 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner lontgonery County Washington Park Adventist lakoma If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral June 3, 19451 M 2 □ F Days Months Hours Min Pennsylvania 194-38-5625 **Director** 66 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Bethesda Md. Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral U.S.A. 20816 5921 Ramsgate Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Lingortant: If item 27 is marked other than 3ry injury or other traumatic event, the N Real Estate Real Estate Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred G. Young R. Larsen Thorbjorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramsgate Rd. Bethesda, Md. 20816 5921 Larsen (Wife) Judith R. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Aug. 31,2011 Riverdale, Md. Chambers Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenser 22 Name and Address of Facility Chambers Funeral Home & Crematorium, Cleveland Ave. Riverdale, Md. 20737 ram 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Due to (or as a consequence of): Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Hospital or Attending Physician: The law requires Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No after death.

Director: After this certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0067427 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Takoma Park reorge 7600 Carroll Avenue, 31. Date filed (Month, Day, Year) AUG 3 1 2011

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are egible. State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar		Cer	tificate of D	eath_		Reg. No.		
	Physicia	n/	1. Decedent's Name (First, Middle, La	·	-			2. Date of Dea		, Year	3. Time of Death
	Medic		Frank Joseph					63	Z 19	11	1000
	Examin	er	4 Facility Name (if not institution, give	ice at the	ake	4b. City, Town, or	Sbur	4	N		MICO
	Funeral Director		161-22-8677	Sex 1 🗓 M 2 🗆 F 7. Age (In yrs. la:	st birthdaỷ) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da 7 / 2 4 /	h V, Yea <i>r)</i> 1931	9. Birth Coui	nplace (State or Foreign ntry) PA
	nd now	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	anylar 3a-f sl	ecto	MD Worce	ester	Ber	lin					1 ☐ Yes 2🔀 No
	the M	ı Dir	10e. Street and Number	35 001		10f. Zip Code			10g. Citizen	of What Cou	ıntry?
	h with	Funeral Director	14 Bimini La				L811			USA	
_	r deat or iten niner r	by Fu	11. Marital Status 1 ☐ Never Married 2 😾 Married	12. Was Decedent Ever in U.S Armed Forces? 12 Yes 2 No	i. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		Race - Ameri Black, White,	
250	rs afte ral", c Exarr	ed b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Sper	cify: wh	ite
9500-c	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest g	Education grade completed)	(Give	dent's Usual Occupa kind of work done o	ation luring most of worl	king	16b. Kind o	of Business In	ndustry
7	rithin 7 iene.	Con	Elementary/Seconday (0-12)	College (1-4 or 5+)		ONOT use retired) ctrical	Engine	er	us (Gover	nment
פר	i be filed withi fental Hygiene rked other th tic event, the	Be	17. Father's Name (First, Middle, Last,	,			18. Mother's Nan		Maiden Surn	ame)	
<u>X</u> a	should be file and Mental I is marked of raumatic eve	오	Joseph L. Lie				Floren				
			19a. Informant's Name/Relationship		1	ng Address (Street a					Code)
<u>ნ</u>	ge 1 and 2 should be it of Health and Men If item 27 is marke or other traumatic		20a. Method of Disposition	20b. Pl	lace of Dispo	sition (Name of		Date Date		ion - City or	Town, State
e E	Page nent o ant: If ıry or		1 ☐ Burial 2 ☐XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	nemovar nom otate	st S	natory or other place tate Cre	em. 8/3				
saltimore,	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other tonce.	1	21. Signature of Funeral Service Live	nsee A /		2. Name and Addres		_			
_			23a. Part 7. Enter the disease, or con	nollications that caused the death		08 Willi				D 210	Approximate
	Physician/		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.							Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. MALIANA Due to (or as a consequ		LANG	CARC	enous			
	Examiner	ڀ	Sequentially list conditions,	b							
	ed sit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ	ience of):					- 1	
	xecute n and al-tran	Exa	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):						
ွ	ifficate be executed ng physician and as the burial-transit	Medical Examiner		d							
09/89			IF FEMALE:	23c. If yes, outcome of pregnal	ncv				004	Data of dat	
Box	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the all endire completed filled in by the funeral director, page 2 should be detached fir tuse.	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d	ıl death 3 L	Ectopic pregnand Other (specify)	cy		230	. Date of deli Month	Day Year
7. Ö.	at the d by th		9 Unknown Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying cause giv	ven in Part I.	23e. Did 1	obacco use o	contribute to	the cause of death?
S,	ires th signe Id be c	d by						1 🗆	Yes 2 🗆 N	No 3□Pi	robably 4 Unknown
Örd	w requ	plete						24a. Was		4b. Were aut	topsy findings available
Yec	The la ate ha page 2	Completed						perf 1 🗆 Yes	ormed2	death?	: 2/5No
Ital	ician: certific ector,	a	25. Was case referred to medical examiner? 1 Yes	Hospital:		Oth	ace of Death (Che		S	2	. HD1816 Fr.
7	Phys rr this eral dir	은 ::	1 Yes 2 No 27. Manner of Death		28b. Time o	f 28c. Injur	y at	lome 5 ☐ Resi 28d. Describe			ify) HOSPICE
ono	anding tath. rr: Afte	licat	Natural 5 Pending Page 1 Pending Pending		injury	M 1 🗆	(? Yes 2 ☐ No				
Division of Vital Records,	l or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			reet, factory, office		28f. Location (City or To	Street and Nu wn, State)	ımber or Rui	ral Route Number,
_	lospita 4 hours uneral ed fillec	Medical	(Check Medical Eva	nysician: To the best of my knowl miner: On the basis of examination	and/or inves	stigation, in my opinie	on, death occurred	at the time, date	and place, and	d due to the a	cause(s) and manner stated.
	the lithin 2 the F	₩	only one) 3 certifying No. 29b. Signature and title of certifier	urse Practioner: To the best of my	y knowledge,	death occurred at the	e time, date and pl	ace, and due to t	ne cause(s) an	nd manner as igned (Month	stated.
	K ≥ K 2		De la constitución de la constit								
	•		30. Name and address of person who			Print)	5-8410 SBUPY		34 -		
ت	1401 1		CHURAN WAR		1733	SALI	sbuff	wp	2/30	7	
	Sta Registr		31. Date filed (Month, Day, Year)	2011 32. Registrar's Signat	d. A	backer	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29556 State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 201°1 8:31 A M August 24 Alexander McAllister Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Carroll Eldersburg 5916 Oklahoma Rd. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 1 M 2 □ F **Funeral** Dec. 13, Year 1921 Days Hours Scotland 89 054-80-6432 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Prince Georges Bowie Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Scotland 5 4 1 Funeral 20715 12635 Kornett Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces 1 Yes 2 No If Yes, Give Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Stone Mason Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marv Curran Alexander McAllister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5916 Oklahoma Rd., Eldersburg, Maryland 21784 19a. Informant's Name/Relationship (Type, Print) Jessie Shopland- Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Lakemont Mem Gardens Aug. 27,201 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert Edes Evans Funeral Home 16000 Annapolis Rd, Bowie, Maryland 20715 ter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disease, or complications that cause the death and not shock, or heart failure. List only one cause on each one. Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a consequance of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate the attending physician and hed for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 No detached been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 1 Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Restdence Other: 4 Nursing Home 5 Residence 2 1 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Certificate: injury 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29d. Date signed (Mghth, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, Maryland 21157, Flavio Kruter, M.D. Center Street 555 32. Registrar's Signature 31. Date filed (Month State AUG 2 9 2011

Registrar

11-06541 Jeffrey Mallick Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

		1- For State Certifi	ment of Health and Mental H icate of Death	Reg. No. 2011 - 2953
Physicia cal Exami		1. Decedent's Name (First, Middle,Last) Jeffrey Chad Mallick		2. Date of Death Month Day Year August 30, 2011 3. Time of Death 1203 hrs
		4a. Facility Name (if not institution, give street and number) 606 E Patrick Street #3	4b. City, Town, or Location of Death Frederick	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 218-04-2837 1 M 2 F 30	oirthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	- Casalan
d now noy			wn or Location ithersburg	10d, Inside City Limit
with the Maryland ns 23a or 28a-f show be notified at ooce.	Director	10e. Street and Number 24132 Doreen Drive	10f. Zip Code 20882	10g. Citizen of What Country? United States
within 72 hours after death with the Maryland gene. ner than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? (Sinf Yes, specify Cuban, Mexican, Puerto	
ted within 72 hours aft Tygiene. other than "natural" the Medical Examine	leted by	or Dates:	Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use ret	work done 16b. Kind of Business/Industry (red)
5 5 5 4 5 4 E	Be Completed	12 0 17. Father's Name (First, Middle, Last) Jeffrey Craig Mallick		Solar Technology (First, Middle, Maiden Surname) Lee Ruzanski
d 2 should be fill th and Mental I in 27 is marked numatic event,		19a. Informant's Name/Relationship (Type, Print) Jeffrey C. Mallick/Father	19b. Mailing Address (Street and Number or 24132 Doreen Drive,	Rural Route Number, City or Town, State, Zip Code) Gaithersburg, Md. 20882
permit. Pages I and 2 shou Department of Health and Nimportant: If item 27 is no jury or other traumatic		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 4 Par		Date 20c. Location - City or Town, State 3/2011 Rockville, Md.
permit. Page Department of Important: Iojury or oth	ār zi	21. Sign fur of Funital Service Libensee/ 23a. Part I. Enter the disease, or complications that caused the death. Do	22. Name and Address of Facility Muriel H. Barber P. O. Box 5038, on tenter the mode of dying, such as cardiac of	Funeral Home Laytonsville, Md. 20882 or respiratory arrest, shock, or heart Approximate Inter
Medical xaminer	Examiner	or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	plicated by methadone	Intoxication Death
certificate be executed nding physician and se as the burial - transit	edical	IF FEMALE: 23c. If yes, outcome of pregnance	-f,per me,g919 9-23-1	1 sm
e death certificate be the attending physici ed for use as the buri	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death 3 Ectopic pregnt 5 Other (Specify)	ancy Month Day Year
es that the igned by be detach	اھ	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknow
law has 2 s	Completed			24a. Was an autopsy findings availar prior to completion of cause of death? 1 V Yes 2 No 1 V Yes 2 No
ag sign	To Be	27. Manner of Death 28a. Date of Injury 28	26.Place of Death (Check /Outpatient 3 DOA Other Nursing D. Time of Injury 28c. Injury at Work?	only one) ng Home 5 Residence 6 🗸 Other: Scene 28d. Describe how injury occurred
ਫ਼ੂੂ∽ਫ਼∥	ertification:	2 Accident Investigation 3 Suicide 6 COuld not be 28e. Place of Injury - At home	d 11:51am 1 Yes 2 No	Unknown 28f. Location (Street and Number or Rural Route Number, Cor Town, State) 606 F Patrick St ポ
To the Hospital or Atteorythin 24 hours after death To the Ruoeral Director: completely filled in by the	Medical Cert	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (check only one) 2 Medical Examiner: On the basis of examination and/or	Residence death occurred at the time, date and place, and or investigation, in my opinion, death occurred	or Town, State) 6.06 E. Patrick St. # Frederick, Md. E. Patrick St. # d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
To t To t	Med	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 31, 2011
		30. Name and address of person who completed cause of death (Item 23a Ana Rubio MD. Assistant Medical Examiner 900	a)) W. Baltimore Street, Baltimore, M	D 21223
S	tate	31. Date filed (Mooth, Day, Year) 2011 32 Registrar's Signature	Carrel	

OCME

State of Maryland / Department of Health and Mental Hygiens State Registrar Amend#2perphysician9/12/11cc@entificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carolyn Lee Messineo Aug 28, 201 22:03 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Aug 26, Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min Months **Director** Washington DC 213 42 7683 Usual Residence of Decedent show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2XX No Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2201 Shadyside Ave 20746 death death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mail Order Dept National Gallery Of Art is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Johnson Roach Lavetta permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Messineo (Daughter) 11609 Kipling Drive, Waldorf, MD 20601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Aug 27, 2011 Clinton, MD 21. Sign Tyre of Funeral Service Licens 22. Name and Address of Facility Lee Funeral Home, Inc 663301d Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death the P.O. signed by t d be detach 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate hemallista 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 \square Pending work Accident 1 Yes 2 🗌 No Investigation 24 hours after deal Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064289 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Varsha Vanikar, M.D. 7501 Surrants Road, Clinton, MD20735 State AUG 29 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 3 Pay 201 Year 10:25A M McConkey, Jr. Roger Albert Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center Charles LaPlata Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours Min (Month, Day, Year) 04/03/1933 Country)
Washington, D.C Director 577-46-1731 78 Usual Residence of Decedent 28a-f shov 10a State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 👿 No Maryland Charles Waldorf ō 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 12781 Jones Lane 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Accountant State Government and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ traumatic Albert Roger McConkey Irma Bernice Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauone. of Health Elaine McConkey/Wife 12781 Jones Lane, Waldorf, MD 20602 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peter's Cath. Cem, 09/06/2011 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Whiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons- uence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No Yes 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: Certificate: To 1XInpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could.not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUM mello Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Lagible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 James Wilson Miedzinski Sept. 9:05 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 26170 Jones Wharf Road St. Mary's Hollywood Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Sex 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 X M 2 D F Hours 219-34-9419 11/29/1938 **Director** Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland St.Mary's Hollywood 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26170 Jones Wharf Road 20636 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ Black, White, etc. 1 Never Married 2 Married 1 Yes 2 🔀 No 1 Yes 2 No Specify: "natural", Completed 3x Widowed 4 □ Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Beverage Distributor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Michael Miedzinski Eva Josephine Copsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Miedzinski/Daughter 43094 Joy Lane, Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) St.John's Catholic 4 ☐ Donation 5 ☐ Other (Specify) 109/08/2011 Hollywood, MD 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home,
41590 Fenwick Street, Leonardtown, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician metastatic CA 22 yes Medical resulting in death) Due to (or as a consequence of) **Examiner** 6 mas. Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Гот ав а фолямоципон об amo that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last lever Jacken and -trar Due to (or as a consequence of): physician a sthe burial-Physician/Medical ding IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: 1 Tyes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical

P.O. Box 68760 Division of Vital Records,

Maryland 21215-0036

Baltimore,

10 ens

P.ANK

29a. Certifier

(Check

only one)

Signature and title of certifie

Day, Year,

wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4216=R

07-40900

1,🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

201

Leonard town

29c. License number

50

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, For State Registrar 29561 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 2:55 P Sept. Shirley Marie Marders Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mary's Hospice House of St. Mary's Callaway Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 1 Year **Funeral** (Month, Day, Year 1 DM 2 XF Months Days Hours Min Director 227-54-1533 Dec Virginia Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director notified 1 Yes 2 X No Virginia King George King George ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be ral", or items 23a -Examiner must be Funeral 10372 Hanover Church 22485 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 2 mingringry or other traumatic event, the Medical Examiner must once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lertie Supthin Edith Cabiness 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22095 Caravel Court Great Mills, MD 20634 Linda Toler / Daughter 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Historyland Cemetery 9-06-2011 King George, Virginia 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signa Edward N. Brinsfield, 22955 Hollywood Road Leonardtown, MD 20650 Jr. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed ending physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day for Month Year Pregnant at time of death detached Unknown a | | Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law has autopsy death? After this certificate Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မြ 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accider iniury work? 1 ☐ Yes 2 ☐ No 5 Pending after death.

Director: Aff Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H005575 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 40900 Merchant's Lane Suite 205 Leonardtown, MD 20650 D.O. Jennifer Schmidt egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are pible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 27 Day 2011 Year Physician/ Irene Pals Monsma 3:13 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Sept. 3, 1917 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min. Country) 1 □ M 2 ☐¥F Hours 480-12-3422 93 IA Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 Yes 2 No MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20901 USA 304 Irwin Street Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Force Black, White, etc. White ☐ Yes 2 🔀 No þ 1 Never Married 2 Married 1 ☐ Yes 2 H No Specify: Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Magdalena Hellena Kooijman Arien Iemka Pals 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 Kerwin Road, Silver Spring, MD 20901 Mary Monsma/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. 2, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Rock Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 Washington, DC Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ STROKE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MYOCARDIAL Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying ATRIAL The law requires that the death certificate be executed use as the burial-trems Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 death? 1 Tes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ပု 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be

Box 68760 P.O. Records, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Division of Vital

Maryland 21215-0036

Baltimore,

Completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 27 2011 72PPP0C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20010 Century Blvd., Germantown, MD 20874 Randall P. Wagner, MD 31. Date filed (Month, Day, Year) State AUG 31 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Physician/ 8:30атм Neumani arald Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mack ell 12206 Bowie 6. Sex 1 🛱 M 2 □ F Social Security Number Year If Under 24 Hrs 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Hours (Month, Day, Year) 284-12-4027 90 Director Ohic Usual Residence of Decedent · 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director Md Prince Georges Bowie 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 12206 Mackell Lane 20715 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 No If Yes, Give Year or Dates. WW II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: White 3 XWidowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72, and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Government Printing Pressman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elsie Schrader Herman Neumann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite Avenue Glenn Dale, Md. 20769 e 1 and 2 s t of Health a If item 27 Carl W. Neumann Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 ☐ Burial 2 I Cremation 3 ☐ Removal from State 8-29-2011 Waldorf, Md 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie, Md 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) andianu Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury and -trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the a g 🗌 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 2 XN 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury 28h. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗌 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, acolo 30. Name and aderess of person who completed cause of death (Item 23a) (Type, Print) 3 lanet M. 31. Date filed (Month, Day, Year) State AUG 2 9 201

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State	State of Maryland / Department of Health Certificate of Death	/ / 4764
	Dhysisia	,	1. Decedent's Name (First, Middle, Last)	1	2. Date of Death 3. Time of Death
	Physicia Medic	al	4a. Facility Name (if not institution, give st.	neet and number)	
أمسد	Examin	er	Fort Washinston	Fort Was	hinston Prince Gourge
	Funeral Director		5. Social Security Number 6. Sex	M 2 \square F 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Yrs. Months Days Hours	er 24 Mrs. 8. Date of Birth 9. Birthplac (State or Foreign Country) Min. 7 4 1 2 5 Marcy on
		Ļ	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Location	10d. Inside City Limits
	// Aarylan 8a-fsh tified a	Director	Maryland Prince Go	corse Fort Washinston	1 □ >105 2 □ No
	h the N 3a or 2 be no	al Di	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	eath wit ems 23 r must	Funeral	11538 Old F	2. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No- 14. Race - American Indian,
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 No 19 To	
9	hours natura	letec	15. Decedent's Edu (Specify only highest grade		16b. Kind of Business Industry
121	thin 72 ane. • than " he Me c	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	Automotive
Maryland 21215-0036	filed willed will Hygis d other vent, t	Be	17. Father's Name (First, Middle, Last)	18. Mo	ther's Name (First, Middle, Maiden Surname)
ryla	ould be d Ment marker matic e	ပ	19a. Informant's Name/Relationship (Type	Newman El	nber or Rural Route Number, City or Town, State, Zip ode)
Ma	d 2 shc alth an 1 27 is er trau		Durethea Edward	s - Dauchter 17105 Livingston	Rd Accokeek MD 20607
ore	ge 1 an nt of He : If iten or oth		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore,	mit. Pall partmer portant r injury 2e.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	1 Resurrection 22. Name and Address of Fac	8-31-11 Clinton My
ä	permi Depar Impo any ir		Theresa M	each Acams Tuner that caused the death. Do not enter the mode of dying, such a	
the second	h, irian/ Medical Examiner	e.	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence of	Interval Between
760	icate be executed physician and s the burial-transit	edical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of):	
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	ic. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
s, P.O.	ires that t signed b Id be deta		Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause given in Pa	art I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	The law requite has been bage 2 shou	Completed by			24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
ta	ician: 1 certifica ector, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 【 No	ospital:Other:	eath (Check only one)
of V	g Physer this erral dir	te: To	27. Manner of Death	1 Inpatient 2 ER/Outpatient 3 IDOA 4 I 28a. Date of injury (Month, Day, Year) 28b. Time of injury work?	Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
sion	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	M 1 ☐ Yes 2 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,
Ω	ital or / irs after ral Dire			building, etc. (Specify)	City or Town, State)
	e Hosp n 24 hol e Funel	Medical	(Check Medical Examin	cian: To the best of my knowledge, death occured at the time, date an er: On the basis of examination and/or investigation, in my opinion, death Practioner: To the best of my knowledge, death occurred at the time, or	n occurred at the time, date and place, and due to the cause(s) and manner stated.
_	To th within To th comp	-	29b. Signature and title of certifier	29c. License numbe	
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, Print)	77111 8 / 65/11
1	LB10		Patrick Dal	y 11711 Livingston Rd. Fo	ort Washington Md. 20744
	Sta Registr		31. Date filed (Month, Day, Year) ALIC 30 2	32. Registrar's Signature	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland /	•	rtment of		and M		giene Reg. No2	011	29565
			Registrar 1. Decedent's Name (First, Middle, La	est)		- 00/1	incate of	Deatri		2. Date of Dea		Uil	3. Time of Death
	Physicia			ENE NI	MOLS	ON				Month Sept.	Day	2011	2:55 P M
	Medic Examin		4a. Facility Name (if not institution, giv	···			4b. City, Town,	or Location	of Death	осре.	4c. Cc	ounty of Dea	
	LXdiiiii		St. Mary's Hospi	ital			Leonar	rdtowr	1		l s	t. Man	cv's
	Funeral		5. Social Security Number 6. 5	Sex 7 Age	e (In yrs. last bi	irthday)	If Under 1 Yea	r If Unde	r 24 Hrs. Min.	8. Date of Birt	h	9. Bi	rthplace (State or Foreign
	Director		220-78-1190	1 □ M 2 X F	47	Yrs.	Months Days	Hours	IVIIII.	Jan. 1	1, 19	64 M	aryland
	d low lt	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Loc	ation						10d. Inside City Limits
	arylan a-fsh iied a	cto											1 ☐ Yes 2 X No
	or 28% notif	Director	Maryland St. Ma	ry's	Love	VILL	10f. Zip Code				10a. Citize	n of What C	ountry?
	/ith th	ral	25977 Loveville	Pond			2065				U.S		·
	ems r mu	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	as Decedent of	Hispanic O	rigin? (Spe	cify Yes or No-			erican Indian,
ဖ	or it	by F	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2	No		Yes, specify Cu			Rican, etc.)		Black, Whi	te, etc.
ဗ္ဗ	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			Yes 2 X	io Specif	y: 		Sp	ecify: Wi	nite
5-	"2 hor "nat edica	Completed	15. Decedent's (Specify only highest g		16 	(Give k	ent's Usual Occi ind of work don	e during mo	st of worki	ng	16b. Kind	of Business	s Industry
7	thin 7 ene. than he M	ĕ	Elementary/Seconday (0-12)	College (1-4 or 5	+)		NOT use retire				Re	tail	
р Б	ed wi Hygie other ent, t	Be (17. Father's Name (First, Middle, Last)			Dar	врство		her's Name	e (First, Middle,			
lan	ould be file nd Mental marked o	욘	Joseph Albert	Tippett				A1	ice	Richar	ds		
ary	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (19	9b. Mailin	g Address (Stree					wn, State, Z	ip Code)
Σ	d 2 sl alth a n 27 i ertra		Karen Casamento	/ Sister		12334	4 Kent S	Street	: King	g Georg	e, Vi	rginia	a
ore	of Heal of Heal fitem		20a. Method of Disposition 1	Demoual from State	20b. Place cemet	of Dispos	sition (Name of atory or other p	lace)	[Date	20c. Loca	ation - City o	r Town, State
Ĕ	Page 1 ment of ant: If it ury or o		4 Donation 5 Other (Spec						09/09	9/2011	Mecha	nicsv	ille, MD
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		21. Signature of Funeral Service Licer	isee of	1000								neral Home
	482.00		23a, Part 1. Enter the disease, or con	polications that caused	MOO8							те на	L1, MD 20622 Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line	001201		C Pall	, ing, odor a	o our and o		,		Interval Between Onset and Death
f	hy sicia n. Medical	02.0	disease or condition resulting in death)	a. Due to (or as a	PATIC		Coru	1					
1	Examiner				EPATIO	e 01): Ĉ	ENCER	MALO	DATA	N			DAYS
	ä	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	<u> </u>			,,,,	- III.	-			214
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	c	CIPR	-HOS	15						1/5778-5
	exec an ar rial-tr	EX	resulting in death) Last	Due to (or as a	consequence	e of):							
00	te be hysici he bu	dical	•	■ d									
687	rtifica ing pl	Me	IF FEMALE:								37		
ž 6	ith cer ittend or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live Birth	2 Fetal dea		Ectopic pregna				23	d. Date of d Month	elivery Day Year
Records, P.O. Box	e dea the a thed f	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 D Unknown	t time or death	1 5 🗆	Other (specify)						
Ö.	hat th ed by detac	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the ur	nderlyin g cause	given in Par	rt I.	23e. Did to	obacco use	contribute	to the cause of death?
s,	ires t	d by								1 🗆	Yes 2 🗆	₩ 6 3 □	Probably 4 🗆 Unknown
ord	requestion shou	lete								24a. Was		24b. Were a	utopsy findings available
ec	ne lav e has age 2	Completed				7 .				autop perfo	ormed?_	death?	es 2 No
<u>e</u>	an; Th tificat tor, pa	Be C	25. Was case referred to medical		-		26.	Place of De	eath (Checi		2 (E) NO		es Z 🗆 NO
Ĕ	ysici is cer direc	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/0	Outpatien	t 3 DOA	ther: 4 🗆 I	Nursing Ho	me 5 Resid	dence 6	Other (Spe	ecify)
ot	ng Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injui (Month, Day	ry 28b	. Time of injury	28c. In	jury at ork?		28d. Describe h	now injury o	occurred	
ion	tendii eath. or: Ai the fu	ifica	2 Accident Investigation	he			M 1	Yes 2	□ No				
Division of Vital	or At after d Direct in by	Certificate:	4 Homicide determined		iry - At home, c. (Specify)	farm, stre	et, factory, offic	e	1	28f. Location (S City or Tov	Street and I vn, State)	Number or F	Tural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.			ysician: To the best of									
	he Ho in 24 t he Fu pletec	Medical	(Check 2 Medical Exar only one) 3 Certifying Nu	niner: On the basis of ex rse Practioner: To the	xamination and best of my kno	t/or investi wledge, d	igation, in my op eath occurred at	inion, death the time, da	occurred a ate and plac	t the time, date a ce, and due to th	and place, a le cause(s) a	nd due to the and manner a	e cause(s) and manner stated. as stated.
	Veith veith of the contract of		29b. Signature and title of certifier		A Ac	7	_	nse number					nth, Day, Year)
	assime				M)			560 0	!			-5-11	
5)(mapph		30. Name and address of person who	completed cause of de	Do.) (Type, P	rint) STN	11/275	no	OFMIA	2 4	EON.	MY MOSTOWN MD
	Stat		31. Date filed (Month, Day, Year)		ar's Signature								
	Registra	ar	SEP 0 9	ZUIII Bus	u p.	-	all						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29566 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Physician/ yIrar Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Knollwood manor MillersvII 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2XX Months Days Rwanda 59 1952 Director 131-96-1254 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Director 1 Yes 2X No North Tonawanda NY Niagra 10g. Citizen of What Country? 10e. Street and Number Funeral Rwanda 14120 286 Rumbold Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Black 3 XWidowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nyiratuza ည Susan Rwamihigo Manasse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 286 Rumbold Ave., North Tonawanda, NY 14120 Jerome Ndayishimiye permit. Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 X Removal from State 08/30/2011 Washington D.C. Glenwood Cemetery 4 Donation 5 Other (Specify) 21. Signature of Fun rai Service Licensee 2. Name and Address of Facility app Funeral and Cremation Services 33 Gist Ave., Silver Spring, MD 20910 Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complica Approximate Interval Between Onset and Death Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical Examiner KNOWV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) uwn the Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial property that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month in the past 12 months?
1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy certificate has performed completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Certificate: To Be examiner? Hospital Other 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28b. Time of 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 2

State Registrar 31. Date filed (Month, Day, Year) AUG 3 1 2011

B my Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

lidewater

26

#IA Amnapolis. MD

MAR し、しに、みん with Maryland 21215-0036

1. Decedent's Name (First, Middle, Last)

25 2011 Physician/ 12:10 PM Lillian M. Poland August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** (Month, Day, Ye ulv 10, Months Hours Min 194-22-0594 81 1930 Pennsylvania **Director** July Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director MD Prince George's Bowie 1 🛛 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 12319 Stonehaven Lane 20715 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Punch Operator Auto Industry other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F မ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 6 Stephen Malinak Julia Kopinza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millersville, MD 21108 Craig F. Poland / Son 236 Michele Circle, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory 8/26/2011 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, Approximate Interval Between nset and Death 23a. Part 1. Enter the disea shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one causes in each line. Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical 68760 ding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ectopic pregnancy
5 Other (specify) ___ signed by the atte in the past 12 months? Year Month Day Pregnant at time of death 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 1 Yes 2 No Division of Vital 25. Was case referred to medica funeral director Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 은 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 1 Natural (Month, Day, Year) 5 Pending n 24 hours after death.

e Funeral Director: Aft
bleted filled in by the fur 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ō Hospital Medical Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 Certifying Nursa, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20706 8118 GOODLUCK ROAD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

3. Time of Death

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Area egible 1 2 9 5 6 8 amend #27 perMD FCHD TM 8/29/11 #18 perFH FCHD TM 8/29/11 State of Maryland / Department of Health and Mental Hygiene

		1	1 - State Registrar Certificate of Death Reg. No.											
	Physicia	n/	1. Decedent's Name (First, Middle, La							2. Date of De Month	Day	Year	3. Time of	
	Medic	al .	CHELSEA CHARLY		PITTM	IAN			(D. II	August		2011	7:01	PM
المسيوب	Examin	GI.	4a. Facility Name (if not institution, giv FREDERICK MEMOF	RIAL HOSPIT	ITAL FREDERICK FE					REDERI		Foreign		
	Funeral Director		220-47-1530	Sex 7. Age 1 □ M 2 🔀 F	(In yrs. las	t birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Bir Oct 5	¹ 1996	Wash	ington,	
	nd how at	_ h	Usual Residence of Decedent 10a. State 10b. County	-	10c. City,	Town or Loc	ation						10d. Inside Cit	y Limits
	/larylar 8a-f s tified	recto	Maryland Freder	rick	Fred	lerick							1X□ Yes	2 🗆 No
	e filed within 72 hours after death with the Maryland filed within 72 hours after Hygiene. At July and cutter than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 1821 Beaver Creek Lane			10f. Zip Code 21702				10g. Citizen of What Country?				
	items		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of Yes, specify Cu	Hispanic O	rigin? (Spe an, Puerto	cify Yes or No- Rican, etc.)	14	. Race - Ame Black, Whit	erican Indian, e. etc.	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland trait Hygiene 1. Wed other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed by	1 🔀 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.	No		☐ Yes 2X N				Sp	ecify:	Black	
2-0	2 hour "natu edical	plet	15. Decedent's (Specify only highest g			(Give k	ent's Usual Occi	during mo	st of worki	ing	16b. Kind	of Business	Industry	
12	ithin 7 iene. r than the Ma	Com	Elementary/Seconday (0-12)	College (1-4 or 5	+)	stude	O NOT use retire : nt	a)			ed	ucatio	on	
pd 2	filed wall Hygal double	Be	17. Father's Name (First, Middle, Last)							e (First, Middle,			aa Antoi	ino
ylaı	ould be file nd Mental marked c	욘	Sendry Pittman							Anton			sa Antoi	Life
	Sh har 7 is trau	3	19a. Informant's Name/Relationship (Sendry Pittman		ner		g Address (Stree Beaver				erick,	Mary:	land 21	702
=	- 4 = 0		20a. Method of Disposition 1 ※Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		20b. Pla	nce of Dispo metery, crep Paul	sition (Name of natory or other p S A.M.E Cemetery	ace)		Date . 2011	1	-	r Town, State , Maryla	and
3altir	permit, Page Department of Important: If any injury or once.	9	21. Sign Ture of Funeral Service Lice		11	. 22	. Name and Add	ress of Faci						2170
	E = 6 0		23a. Part 1. Enter the disease, or cor	mplications that caused	the death.						_		Approximat	е
F	Ph_sician/	3 33	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	Cor	lion	Mona	8 1	wre	s 1			Interval Bet Onset and [
mark	Medical Examiner		resulting in death) a. Due to (or as a consequence of):											
		Jer.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a conseque	ence of):	Dete	ct					-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	· Hydr	ceph	nalus	<u> </u>							
	tificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as	a conseque	ence of):								
8760	cate b physic	Medical		d										
89 xc	ath certifi attending I for use a	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregna Other (specify)				23	3d. Date of d		Year
В	the dea by the a	Physician,	1 Yes 2 No 9 Unknown	g 🗌 Unknown										
Division of Vital Records, P.O. Box	requires that the derbeen signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						rt 1.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown				
ord	v requi	Completed								24a. Was	s an opsy	24b. Were a	utopsy findings a	available ause of
Rec	sician: The law certificate has b lirector, page 2 s	Som								per	ormed?	death?		
ita	nysician: nis certifica director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	N -1			Place of De				7.00		
of <	g Phys er this eral dii	e: To	27. Manner of Death	28a. Date of inju	ry :	28b. Time of	Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify) D. Time of 28c. Injury at 28d. Describe how injury occurred					ecity)		
on	eath. or: After the funer	Certificate:	1X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide			injury work? M 1 1 Yes 2 No			□No					
Sivis	ipital or Attendi ours after death- eral Director: A filled in by the ft					ne, farm, street, factory, office				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 142 hours after death. To the Funeral Director. Atter this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of e urse Practioner: To the	xamination	and/or inves	tigation, in my op	inion, death	occurred a	at the time, date	and place, a	and due to the	e cause(s) and ma	anner stated.
	To the compl	2	only one) 3 ☐ Certifying No 29b. Signature and title of certifier	1 0.0		ougo,	29c. Lice	nse nu mb e	r		29d. Date	signed (Mon	nth, Day, Year)	
	_		fam tun	sen im	ooth (II	220) /5:	mo!	3419	061		08-	20-2	<u> ७।।</u>	
	2		Faul them M mod 41861 08-20-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Feinberg 1475 Tanay Ave Frederick, MD 21702											
	Sta Registr		31. Date filed (Month, Day, (29)) AUG 29 2	2011 32. Registr.	ar's Signati	ure.	arked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29569 For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lillie Proctor Aug 27, Irene 7:06 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Waldorf 10904 Maryland Woods Court 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 T Sept 15, 1918 Maryland Director 217 42 4039 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Tes 2XX No Maryland 1 Charles Waldorf 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10904 Maryland Woods Court 20602 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give XX Year or Dates. within 72 hours after Specify: Native American Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry دماله be filed المالية. خوا Hygiene. خود than "r" (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Hame should be filed within and Mental Hygiens 7 is marked other th Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marker any injury over ... မ Eugene Newman Mary Marie Savoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10904 Maryland Woods Court, Waldorf, MD 20602 Catherine D. Currie (daughter) Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Resurrection Cemetery Sept 10, 2011 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Jof Funeral Pervice Licensee ^{22. Name and Address of Facility} Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 MU139 Plat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/) ementi disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🛣 No Year Month Day Pregnant at time of death the hed g Unknown ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ step arthritis Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an s certificate has be director, page 2 s autopsy performed 1 Yes 2 No **Division of Vital** 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 🗆 Nursing Home 5 🗶 Residence 6 🗀 Other (Specify) 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0052999 recui des 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7285

Registrar DHMH 17 Rev 7/2009

State

racke

MD

32. Redistrar's Signature

RAHIMIANS

SEP 0

31. Date filed (Month, Day, Year)

10403 Hospital Drive 6-06 CLINTON MD20731

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:26 P August 21 2011 Ethel Pearl Prussia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** National Lutheran Home Rockville Montgomery If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Month, Day, Ye. Days Hours Min 1 M 2 V Director 1925 Jamaica 212-80-1871 86 Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 608 Pebble Beach Drive 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: African-America 1 and 2 should be filed within 72 hours afti of Health and Mental Hygiene. item 27 is marked other than "natural", other traumatic event, the Medical Exal Completed 3 X Widowed 4 Divorced Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Hospitality 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Abraham Scott Margaret Herron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Bevin Prussia, Son 608 Pebble Beach Drive, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Gate of Heaven Cemetery 9/3/2011 21. Signatury of Funeral Service Licensee MO1102 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition En Phylician ctag YPars Medical resulting in death) Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (bries a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physiciar Physician/Medical that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day ō Yea detached 9 Unknown P.O. ģ been signed k should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ mellitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, the Hospital or Attending Physician: The law requires Completed page 2 should 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed? Yes 2 1 No certificate 1 Yes 2 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific Completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Tyes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending work' 1 🗌 Yes 2 🖵 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 0

Registrar
DHMH 17 Rev 7/2009

State

SAMUEL

31. Date filed (Month, Day, Year)

Kockuille

9701 Veirs Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALLER

٠٠)

AUG 31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8/26/2011 2:34 A Doris Major Payne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis <u> Anne Arundel</u> Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Hours **Director** 221-20-5825 1 🗆 M 2 🍱 F 78 7/31/1933 DE ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 No VA Accomack Greenbackville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37119 Saber Ct. 23356 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 1 ☐ Yes 🗶 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates. of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bd of Education teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert P. Major Anna Rae Whiteman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37119 Saber Ct. Greenbackville, VA 23356 Nelson Payne (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a Method of Disposition permit. Page 1 Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State All Hallows Churchyard 8/31/2011 | Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home Signatur Service License 108 William St. Berlin, MD 21811 Part 1. Enter the disease or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on/each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ piration disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Sequentially list conditions, cause (Disease or injury Due to (or as a consequence of) Spinal cord
Due to (or as a consequence of): cord use as the burial-tran that initiated events resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death Other (specify) Yes been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number wo 8510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ohen BA 7 Olexo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29572 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2:10 M James Richard Ridenour 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth Min. (Month, Day, Hours MD213-80-3386 Sept. Usual Residence of Decedent Sep 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21740 11210 Marbern Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 2 No 1 Yes 2 No Specify: If Yes. Give Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ray Howard Ridenour Grace Eileen Crump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) West Moser Road, Apt. 25B, Thurmont, MD. 21788 Marion Ridenour / Sister Aug. Date 30, 2011 Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Resthaven Mem. Garden Aug. 30, 2001 Frederick, MD. 21. Signature of Juneral Service License 22. Name and Address of Facility Robert E. Dailey & Son F.H. P.A. 615 East Main Street, Thurmont, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 5 6 Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linium) Due to for as a consequence of:

Physician/ Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and physician a Division of Vital Records, P.O. Box 68760 as t

Physician/

Medical

10a. State

MD.

Director

Funeral

ģ

Completed

Be

ဂ

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

signed by the attending I has certificate within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral

that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							
Part II. Other significant conditions	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown							
nen	Seizure Diserder mental Retardation 24a. Was an autopsy performer 1 Yes 2 E							
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 Yes 2 No	spital: 1							
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	(Month, Day, Year) injury work? ion M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								

29c. License number

1126

0060396

0001

29d. Date signed (Month, Day, Year)

45

21742

25

Hag

5

Registrar

State

only one) 29b. Signature and title of certifier

31. Date filed (Month

ARID

Yea 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MURSHED

Registrar's Signature

acks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aug 30, 2011 Louise Grav Russell 06:16 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton 5. Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days 579 38 6010 81 **Director** 1930 Maryland Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 1 Yes Y No Maryland Prince George's Forestville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 3504 Springdale Ave 20747 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner Black, White, etc. ö ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify 3 ₩Widowed 4 □ Divorced Specify Completed White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked ot r other traumatic ever P Ralph A. Gray Eleanor Nellie Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Russell (Son) 3504 Springdale Ave, Forestville, MD 20747 Department of Heali Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Sept 6, 2011 4 ☐ Donation 5 ☐ Other (Specify) Forestville, MD Epiphany Episcopal Church Cemetery . Signatu 🎻 f Funeral Sep⁄ice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MOI Ferry Road, Clinton, MD 20735 23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Priysician/ Atheroschewic Cardiovascular diseme Acute disease or condition Medical resulting in death) Examiner Hypertenerm Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of,: attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be FIBRILATION P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Records, DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed yes 2 page 2 s has this certificate 2 No 1 Yes **Division of Vital** Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ≥ No ပ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 3 🗌 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) K MD MAL 08/30/201 D50689 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILK MAHAJAN (Y) D Southern 503 Syrratts RUG Chinno ms 31. Date filed (Month) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2011 State
Registrar Amend#20bperfunera19/12/11c@ertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ GGLEMA WANEDA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b, City, Town, or Location of Death Prince George's 3314 Pinvale Ave Forestville 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) r 1 Year If Under 24 Hrs. **Funeral** 236 48 3238 81 **Director** 1 □ M 2 🗶 F June 28, 1930 West Virginia or 28a-f show notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If items 23a or 28a-f sho Important: If item 275 is marked other than "natural", or items 23a or 28a-f sho any hijury or other traumatic event, the Medical Examiner must be notified at any hijury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Funeral Director 1 Tes 2 XXNo Prince George's Maryland Forestville 10g. Citizen of What Country? 3314 Pinevale Ave United States 20747 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 XXMarried Yes 2 No Yes, Give XX Baltimore, Maryland 21215-0036 1 Yes 2 XX Specify 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Prince George County <u>Bus Aide</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Evers Swick Pauline Delawder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3314 Pinevale Ave, Forestville, MD 20747 Elmer D. Riggleman (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept.8,2011 1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery Sept 3, 2011 Cheltenham, MD 21. Signature of Funeral Se 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) as the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy
☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown detached for Month Year Day Pregnant at time of death g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 No 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral Medical Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accider iniury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 7 Rio 31. Date filed (Month Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 19a per inf g920 10-12-11 vt State of Maryland / Department of Health and Mental Hygien [] For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month 1:30 A-M AUGUST 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomeri HOSPITAL Lr033 If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 28 1 DM 2 DF Guatemala Director Nevember 12,190 Usual Residence of Deceden 28a-f shov 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10d. Inside City Limits Completed by Funeral Director must be notified Silver Spring 1 Yes 2 No Maryland 10g. Citizen of What Country? 23a or 20903 9706 Mount Guatema er than "natural", or items the Medical Examiner mu . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian Armed Forces 1 Never Married 2 Married 2 No ☐ Yes Maryland 21215-0036 1 1 Yes 2 No Specify: Gratemalan If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the N Elementary/Seconday (0-12) College (1-4 or 5+) abor 12 To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Ortega Mejia Daniel 19a Salla Raquel Sanchez Martinez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Heatth ar Important: If item 27 is any injury or other trau Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, c 1 Burial 2 Cremation 3 Removal from State vatemala 4 Donation 5 Other (Specify) 145+ N.W. . Scnature of Funeral Service I cens Name and Addres WASh., DE 20010 23a. Part 1. Enter the disease, or complications that ca dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner within 24 hours: iter death.

To the Funeral Unector After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month * Year Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Natural
Accident
Suicide
Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of c 29c. License number 29d. Date signed (Manth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Satyam A. Shah, MOB 500 Pluad 0910 KN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2011 Registrar and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Minervia Robinson SEPTEMBER 2011 11:09AM1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Boonsboro Reeders Memorial Home g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year uly 2, 1 Days Min. Months Hours 1 □ M 2 🔽 F 90 213-16-0986 Yrs Maryland Director Julu Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10a, State 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2X No 28a-f Smithsburg Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral 21783 items 23a 23240 Foxville Road U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2X No
If Yes, Give Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2X No Specify Specify: "natural", 3 ☑ Widowed 4 ☐ Divorced Completed White Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) OBINSON, Skiver Shoe Factory 3 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary G. McNeal Charles W. Guessford or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22416 Goose Street Smithsburg, Maryland 21783 Sandra F. Kendle (Daughter) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State September Smithsburg, Maryland Smithsburg Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 15, 2011 J.L. Davis Funeral Home Signature of Funeral Service Licensee 22. Name and Address of Facility MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 560515 2-3DAYS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 20175 PROBABLY 50 WE (S < htenic Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant g Unknown Pregnant at time of death peu 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be INFECTION DIMBETES 1 Yes 2 No 3 Probably 4 Thinknown TRACT Completed been NTPRRTENSION 24b. Were autopsy findings available 24a, Was an ABTERT DISEASE HYPRILIPEDEMIA prior to completion of cause of death? has autopsy page 2 performed? Yes 2 No 1 Yes 2 No DEMENTIK After this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director Be Other: 4 Addising Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Anatural 5 Pending 24 hours after death. Funeral Director: A Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29c. License number 29d. Date signed (Month, Day, Year) 2 29b. Signature and title of certifier out mo 018419 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-739-7100 340 MILL STREET, HAGERSTOWN, MARYLAND 21740

Registrar DHMH 17 Rev 7/2009

State

VASANT DATTA

SEP 1 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 735 a.M Physician/ 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NMSo Hage (STOWA Nash Hage (st If Under 1 Year of Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 1 1 M 2 F Maryland **Director** 220-64-2135 5/8/1955 Usual Residence of Decedent 10d Inside City Limits or 28a-f shov 10b County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland must be notified at **Funeral Director** Yes 2 No MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a of any injury or other traumatic event, the Medical Examiner must be North 21740 Locust Street U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: If Yes, Give Year or Dates Completed 3 - Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Financing Finance Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Raymond Bartles T. Wendy Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell Hull / Companion Hagerstown, MD 21742 13023 Little Hayden Circle, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory 9/12/2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ocenal Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year for Month 5 Other (specify) Pregnant at time of death 9 Unknown be detached signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔭 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate has autopsy page performed' Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director, Be Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: injury 1 💢 Natural 5 Pending s after death. 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 - Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29d. Date signed (Month, Day, Year)

State Registrar

Su

140,4

bocody.

oncordinarius

32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OWG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 24, John Somerville Snyder, Jr. 201 Ta 11:07A. M Medical 4c. County of Death
Frederick 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Monrovia 3009 White Pine Drive Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, 1 X M 2 🗆 F Months Davs Hours New York 056-32-3733 71 1940 Director July Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location notified at Director Monrovia Frederick Maryland 28a-f 1 Yes 2X No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code must be 23a Funeral United States 21770 3009 White Pine Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White "natural", 3 Divorced 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within Communications Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Sophia Smith John Somerville Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 3009 White Pine Drive, Monrovia, MD 21770 Carol Snyder / Wife 3altimore, 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Frederick, Maryland 8/28/2011 Resthaven 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home 21771 8 East Ridgeville Blvd., Mt. Airy, MD shock, or heart fallure List only one cause on a ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Preumani Medical resulting in death) Due to (or, **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No should be detached for Dav 5 Other (specify) the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Records, Hypertension Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Di sease Porkinson autopsy has this certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific. Division of Vital 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home XX Residence 6 Other (Specify) 6 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 \square Pending Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2. only one nd itle of certifier 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) egistrar's Signatu State 29

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | |

0	0		7	0
6	y	J	- /	フ

		•	For State Registrar	Otate of Maryland		rificate of D			eg. No.	2,5015
	Physicia	n/	Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death
	Medic	al	Edward Alexander 4a. Facility Name (if not institution, give str		т		Landin of Dark	August	18, 2011 Year	
	Examin	er	18151 St. Jerome			Damer	Location of Death		4c. County of De St. Mai	
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 07/24/]	Year) 9. B	tirthplace (State or Foreign Country)
	Director		578-58-5274 Usual Residence of Decedent	66	Yrs.			07/24/1	1945 Was	hington, D.C.
	yland f shov	iç	10a. State 10b. County		, Town or Loc	ation				10d. Inside City Limits
	e Mar r 28a- notifie	Director	Maryland St. Mary's	5 Dan	meron	10f. Zip Code			10g. Citizen of What (1 Yes 2 X No
	with th 23a o sst be	Funeral	18151 St. Jerome	s Neck Road		20628			U.S.A.	Southly.
	items		11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	5. 13. W	as Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		nerican Indian,
36	ould be filed within 72 hours after death with the Maryland id Mental Hygiene. marked other than "hatural", or items 23a or 28a-f show marke other than "hatural", or items 23a or 28a-f show marke ovent, the Medical Examiner must be notified at	d by	1 Never Married 2 X Married 3	1 X Yes 2 □ No If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		Specify: Wh	
21215-0036	natur dical E	Completed	15. Decedent's Educ (Specify only highest grade	cation		ent's Usual Occupa	ation luning most of work	ing	16b. Kind of Busines	ss Industry
121	thin 72 ane. than and the new ne Mer	omi	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	NOT use retired)	dilling most of wom	9	Educati	
	filed wit tal Hygie d other event, the	Be	17. Father's Name (First, Middle, Last)	5+	Pro	fessor	18. Mother's Nam	e (First, Middle, N	Educati Maiden Surname)	LOII
/lan	d be fi Mental arked atic ev	2	Edward Daniel Sch	auf			Carolin	e Homme	1	
Maryland	12 should be fulth and Menta 27 is marked r traumatic er		19a. Informant's Name/Relationship (Type		1				City or Town, State,	
	and 2 Health tem 27		Judith Schauf/Wi			St. Jero		k Road,	Dameron, 20c. Location - City	
Baltimore,	- 5 E C		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Ctoto C	emeterv. crem	atory or other plac	e) !		Davidsonvi	
alti	permit. Page Department (Important: II any injury or once.		21. Sign rule of Funeral Service License	0 _	22.	Name and Addres	s of Facility Bri	nsfield-	-Echols F.	H., P.A.
<u> </u>	20 E P 0		23a, Part 1. Erfter the disease, or complic	MOO8						1, MD 20622 Approximate
١,			shock, or heart failure. List only one Immediate Cause (Final	cause on each line.			y, such as cardiac	or respiratory arre	551,	Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Metastatic Due to (or as a consequ		oma				1
	Examiner	ŗ	Sequentially list conditions, b.							
	sit sd	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ	ience of):					
	xecute n and al-tran	Еха	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):					
00	death certificate be executed he attending physician and ed for use as the burial-transit	Medical	C d							
68760	rtificat ling ph e as th	/Mec	IF FEMALE:	to If you cuttoome of program	nov		-			
Box (eath certif attending I for use a	sician/\	in the past 12 months?	ic. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c	aldeath 3	Ectopic pregnance Other (specify)	ży		23d. Date of Month	delivery Day Year
Ö.	requires that the de been signed by the should be detached	Physi	1	g 🗌 Unknown						
P.0.	s that gned b	ð	Part II. Other significant conditions conf	tributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.			e to the cause of death?
rds	equire been si hould I	eted							1.0.00	Probably 4 Unknown autopsy findings available
Division of Vital Records,	e law r e has b ge 2 s	Completed					<u> </u>	24a. Was a autop perfor	sy prior death	to completion of cause of
a B	an: Th tificate tor, pa	Be Co	25. Was case referred to medical			26. PI	ace of Death (Chec	1 _ Yes k only one)	2 X No 1 L	Yes 2 □ No
Ž	hysici his cer Il direc	10 E	1 LI Yes 2 LA No	ospital: 1 Inpatient 2			4 ☐ Nursing H	ome 5 Resid	ence 6 🕱 Other (Sp	Hospice House
n of	ding P h. After ti funera		27. Manner of Death 1 X Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆		28d. Describe h	ow injury occurred	nouse
Siol	Attendar death	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	me, farm, stre		res 2 🗆 140		treet and Number or	Rural Route Number,
Σ	tal or is after al Directory		4 - Horriciae aeterminea	building, etc. (Specify	") 			City or Tow	n, State)	
	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 Medical Examine		n and/or invest	igation, in my opinio	on, death occurred a	at the time, date a	nd place, and due to tl	he cause(s) and manner stated.
	To the within To the Somple	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of pertifier	Practioner: To the best of my	y knowledge, c	29c. License	e number		e cause(s) and manner 29d. Date signed (Mo	
			1 - XV	\mathcal{M}		HU	11557	51	8 20	011
.7	127-		30. Name and address of person who cor					1	D 20450	
U	LBID Sta	to	Jennifer Schmidt, 31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture		, Leonard	itown, M	<u> </u>	
	Registr		AUG 30 20	111 Senera	1. 1	arkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	i yiai la i	•	tificate of D			Reg. No. 2		29580
	Physicia	n/	1. Decedent's Name (First, Middle, Las Mary Madeline S						2. Date of Dea Month August	23,	20 ¹	3. Time of Death 2:34A M
	Medic Examin	al	4a. Facility Name (if not institution, give				4b. City, Town, or	Location of Death			ty of Death	2.J4A
_		ш	Fort Washington 5. Social Security Number 6. Se			for the form of the colonical	Fort I	Washingto			nce Ge	orges place (State or Foreign
	Funeral Director		220-16-8745	M 2 XF	(In yrs. last l	Yrs.	Months Days	Hours Min.	April 2	5,1926		yland
	show at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation				1	0d. Inside City Limits
	Maryla 28a-f s otified	Director	Md Charl	es		La P	lata					1 🗆 Yes 2 🔀 No
	ith the 23a or st be n	ral D	10e. Street and Number 5805 Washington	Ave.			10f. Zip Code	646		10g. Citizen o		ntry?
	death v items ier mu	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ	
036	s after or ral", or Examir	Completed by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	10	- 1	☐ Yes 2x No			Spec	70 1	ack
-ç	"natur edical	plete	15. Decedent's Ed (Specify only highest gra		1	(Give k	ent's Usual Occup-	ation during most of wor	king	16b. Kind of	Business In	dustry
717	within 7 giene. sr than the M	Con	Elementary/Seconday (0-12)	College (1-4 or 5-	+)		NOT use retired) memaker				Home	
Maryland 21215-0036	I 2 should be filed within 72 hours after death with the Maryland than dendlarly lighter. 27 its marked other than "natural", or items 28a or 28a-f show 27 its marked other than "natural", or items 26a or 28a-f show traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Harris Hemsley	-				18. Mother's Nan	ne (First, Middle, t ta L. F		me)	
aryt	hould band Me snd Me s mark umatic		19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailin	g Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town	, State, Zip	Code)
Ž	and 2 sleatth a sm 27 i		Margaret Seward/D	aughter	Looi Bi		Bertha C	ircle, I		ad, MD_	20640	
Baltimore,	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 2' is marked any injury or other traumatic ev once.		20a. Method of Disposition 1	Removal from State	Sac	e of Dispo etery, cren red H	sition (Name of natory or other place eart Ceme	etery 8/2	Date 29/2011	La Pla	ata,M)
Salti	ermit. F Separtm mporta ny inju		21. Signature of Funeral Service Licens		M0094.	5 22	ARCHARTE					
	ED = 60	Н	23a. Part 1. Enter the disease, or com	olications that caused	the death. D	o not ente	211 St. I				D 2064	Approximate
4	าเงราตเลาภ	0 1	shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.	155711	VE I	TEMT A	PAILUNE				Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):	to CANO	ou mole	3704			4411
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequen	ce oi).	HEMT F LE CARD - HAM	70((,)				
	cate be executed physician and the burial-transit	Exam	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a			- 1750	المار المناع الم				
160	icate be executed 3 physician and 1s the burial-transi	lical		d			<u>-</u>					
6876	certificat inding ph use as th	/Mec	IF FEMALE:	23c. If yes, outcome of	of pregnancy	y				23d	Date of deliv	verv
	requires that the death certific been signed by the attending is should be detached for use as	Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live Birth : 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal de	eath 3	Ectopic pregnand Other (specify)	ру			Month	Day Year
P.O. Box	hat the ed by th detache	y Phy	9 ☐ Unknown Part II. Other significant conditions c		ut not resulti	ing in the u	nderlying cause gi	ven in Part I.	23e. Did t	obacco use co	ontribute to	the cause of death?
	quires then signer and be	ed by	DEMONTA				-		1 🗆	Yes 2 X N	o 3 🗆 Pro	obably 4 🗆 Unknown
SCOL	The law requires that the ate has been signed by the page 2 should be detach	Completed	ATHEROSCIE	Rosij					24a. Was auto perfe		prior to co death?	opsy findings available ompletion of cause of
al Re	sician: The law r certificate has b irector, page 2 s	Be Co	25. Was case referred to medical		_	_	26. P	lace of Death (Che		2 X No	1 Yes	2 L No
₹	Physician: this certific al director,	To B	examiner? X No				nt 3 DCA Cth	4 L Nursing I	lome 5 Resi			fy)
n of	ding P th. After the funera	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of injur (Month, Day	y Year)	3b. Time of injury	work		28d. Describe l	how injury occ	urred	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death: To the Funeral Director. After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be 4 Homicide determined			28f. Location (City or To		mber or Run	al Route Number,			
Ω	Hospital of 24 hours a Funeral D	Medical	(Chook 2 Medical Evam	sician: To the best of i	camination at	nd/or inves	tigation, in my opini	on, death occurred	at the time, date	and place, and	due to the c	ause(s) and manner stated.
	o the Frithin 24 o the Frithin 24 o the Frithe Frithe Frither	Me	only one) 3 Certifying Nur 29b. Signature and title of ertifjer	se Practioner: To the	oest of my kr	nowledge,	death occurred at the 29c. Licens	ne time, date and pl	ace, and due to the	ne cause(s) and 29d. Date sig	manner as	stated.
	F > F 0		I JAN	hs]	D37467		Aug	ust 24	4, 2011
R	187		30. Name and address of person who F. ALEXAMEDER LE				Print) Washingto	on Rd. St	uite 301	0, Wal	dorf,N	D 20602
	Sta Registr		31. Date filed (Month, Day, Year) AUG 26	32. Registra			pash					
	- regioti		חטע אין	CONT. PAR	- C- CO	100	7					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 29 2011 ear 8:50 P Betty Jane Strissel 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Calvert Calvert Hospice House Prince Frederick 8. Date of Birth 9. Birthplace (Standard Month Day Year) 1923 Georgia If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Days Min. Months Hours 1 □ M 2 😿 F 88 255-28-4041 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 XYes 2 □ No Maryland Calvert Prince Frederick 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20678 USA 4559 Sixes Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No White 1 □Yes 2 No If Yes, Give Year or Dates: Specify Specify. 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Spinks Hyman Beauregard Hyman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6150 Ivy Hill Court, Hughesville, MD 20637 Christopher Strissel/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 4 □ Donation 5 □ Other (Specify) 1, 2011 Cheltenham, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Fugeral Service License 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple disease or condition resulting in death) Due to (or as a consequence of): r terioscler Due to (or as a consequence of): Due to (or as a consequence IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

and

physician

this certificate

After this certification, I

Hospital or Attending Physician:

r death.

To the Hospital within 24 hours a To the Funeral I

O) Rme

a er dea

for use as the burial-tran

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Examine

Physician/Medical

3

Completed

Be

Certification: To

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Exemination must be notified at

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

φ.

Completed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Oronary 25. Was case referred to medical examiner?

31. Date filed (Month, Day, Year)

Date of Injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 105 PICE 28d. Describe how injury occurred 28c. Injury at Work?

House

1 Yes 2 40 27. Manner of Death 1 Natural 2 Accident

> 3 Suicide 4 Homicide

5 Pending investigation Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) d manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

n who com leted cause of death (Item 23a) (Type, Print) 30 Name and address of per aymor

238 Merrimac Ct. Prince Frederick, 41 17 Noble

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Physician/ 11:55 PM 2011 Sept. Sullivan Jr. Bernard Franklin Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Mary's Inigoes 11717 Jutland Drive 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) June 3, 1939 **Funeral** 1 **X**M 2 □ F Days Hours Min. Washington, D.C 579-46-4940 72 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director 1 ☐ Yes 2 🛛 No St. Mary's St. Inigoes Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 20684 11717 Jutland Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 ▲ Yes 2 □
If Yes, Give 1 Never Married 2 Married þ ☐ Yes 2 No Specify Maryland 21215-0036 Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) should be filed within 7 n and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Building Maintenance Stationary Steam Engineer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event; 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ္ Gertrude Louise Merchant Franklin Sullivan Bernard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 99 Dameron, MD 20628 Joseph W. Sullivan / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Charlotte Hall, MD 09/07/2011 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 22. Name and Address of Facility Brinsfield Funeral Home, P.A. off unoral Service Linears dward N. Brinsfield, 22955 Hollywood Road Leonardtown, MD 20650 M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between shock, or heart failure. List only one cause on each line. MoNTHS Immediate Cause (Final CARCINONA Physician/ ETASIATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery nse 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy signed by the atten d be detached for u Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has funeral director, page 2 performed? death? 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 5 Pending 1 X Natural 1 Yes 2 No 24 hours af er death. Funeral Director Af Investigation Accident 2 Accident
3 Suicide
4 Homicide the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 106 6884 /201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR · MARY'S HOSPITAL, 25200 POINT LEONARDIOUN LODKOUI KHAN, 32 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:47P M George Stryker 2011 Robert September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospice House of St. Mary's Callaway If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 M M 2 D F Months 58 214-60-3137 **Director** 01/26/1953 Virginia Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County at 10c. City. Town or Location Director notified 1 Yes 2 X No Maryland St. Mary's **Mechanicsville** 10g. Citizen of What Country? 0 10e Street and Number must be Funeral 23a 28965 Autumnwood Dr. 20659 USA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc ō þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 er than "natural", c ;, the Medical Exam 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Health Care Nurse other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other there are 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ George Bernard Striker, Jr. Estelle Nulman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 736 Warwick Rd., Baltimore, MD 21229 Benjamin Stryker/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-EcholsCrem. 09/06/2011 Charlotte Hall, MD 21. Signatus of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 _MOO817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence oi) that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year Other (specify) Pregnant at time of death signed by the a g Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
 Funeral Director: After this certificate has been signed by th 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 🗆 Yes 2 🕽 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence HOSpice 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) 15450 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural Natural 5 Pending 1 Yes 2 🗌 No Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) H0055751 -60-11 f person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Schmidt, DO, 40900 Merchant's Lane, #205, Leonardtown, MD 20650 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2011 29581 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mabel Slocum. August 28, 2011 Louise 3:11 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 19624 Islander Street 01ney Montgomery Social Security Number if Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) NY 8. Date of Birth 1 🗆 M 2🏗 F Days July 10, Year 25 **Director** 86 131-18-0615 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 Yes 2 No Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 13923 Blair Stone Lane 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:White 3 X Widowed 4 ☐ Divorced "natural" Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ould be filed within 72 nd Mental Hygiene, marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Christopher Paul Leimbach Victoria Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 James P. Slocum/Son P.O. Box 941, Palm City, FL 34991 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sept 2011 4 Donation 5 Other (Specify) Parklawn Memorial Park Rockville, MD Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Renal Disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) nding physician and use as the burial-transm Exam Encephalopathy that initiated events resulting in death) Last Due to (or as a consequence of) Dementia Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 XNo Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypothyroidism, Left Ankle Ulcer, Hypertension, Completed 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown History of Breast Cancer 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter's home 1 ☐ Yes 2 🛂 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) To the Hospital or Attending within 24 hours after death.

To the Funeral Director. After gompleted filled in by the funnity. 2 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🚣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my line while guide. At the time, date and place, and due to the cause(s) and manner stated 29b. Signatu 29d. Date signed (Month, Day, Year)

State Registrar

Box 68760

P.O.

Records,

Division of Vital

AUG 3 1 2011 DHMH 17 Rev 7/2009

1680 East Gude Drive, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Douglas C. Frankel, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State of Marylar State Registra, AMEND#4aperMD, 8/31/11; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 10:32 PM 201 Medical 4a. Facility Name (if not institution, give street and number)
University of Maryland Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Center Bultimore 8. Date of Birth (Month, Day, April 1 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Day, 1 X M 2 □ F Hours Min. 185-70-6493 1989 Pennsylvania 22 Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No MD Germantown Montgomery 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 14001 Falconcrest Road 20874 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kenneth Brian Sheely Kristen Lynn Thomson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Brian Sheely (Father) 14001 Falconcrest Road, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metropolitan
Crematory 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility
Devol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD/20877 21. Signature of Funeral Service Ligensee RACIA STUVE M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator arrest shock, or heart failure. List only one cause on each line. Ap ate erval Between Immediate Cause (Final Onset and Death Priysician/ INI disease or condition rayman Medical resulting in death) ACAPON NA PROVED BY MEDICAL COLUMNES **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral invertion, page 2 should be detached for use as the burnard marking as Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical CERT Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: ٩ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 🔲 Natural work?
1 ☐ Yes 2 No 8 Prac 10:00 AM 12 2011 Investigation 6 Could not be Suicide Pace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town 4 Homicide determined Town, State) Stak Frostburgo MD 2173 trost burg Universit 101 Medical 29a. Certifier Certifying Physician: To the best of only knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 28 201 101109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 37 Registrar's Sign State AUG 3 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29586 State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30 2011 Elizabeth B. Sandoz August 12:30 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 3010 North Ridge Rd. #707 Ellicott City 5. Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Date of Birth **Funeral** Min 1 □ M 2 🔀 F Hours (TT#2%1\916 North Carolina 94 577-18-9338 **Director** Usual Residence of Decedent 23a or 28a-f show ast be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Howard Ellicott City 1 ☐ Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA item 27 is marked other than "natural", or items 23 other traumatic event, the Medic ■ Examiner must I 3010 North Ridge Road #707 21043 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 7 h and Mental Hygiene.
7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ J. Aug Baker Sallie A. Scaff 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8294 Church Lane Drive Ellicott City, Md. 21043 19a. Informant's Name/Relationship (Type, Print) Department of Health as Important: If item 27 is any injury or other trac Page 1 and 2 siment of Health a Rena Stricker/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/30/2011 Hanover, MD Ardent Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ ATHEROSCLEA. MC CARDIO VASCULAR disease or condition resulting in death) GERAS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ Year Month Pregnant at time of death ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral (28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 Natural 5 Pending injury Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature an 15/860 MO ess of person who completed cause of death (Item 23a) (Type, Print) FISH 10700 CHARTER COUNMAIA JONATHAN egistrar's Signature State 2011

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Kreun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Amonth -Physician/ Year 2011 Raymond Moulton Sawyer Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Salish Porinsula Wicomico Regional Medical center If Under 1 Year If Under 24 Hrs 8 Date of Birth Birthplace (State or Foreign Country)
 N 7 5 Social Security Number 021-22-4010 7. Age (In yrs. last birthday, **Funeral** 1 🔀 M 2 🗆 F 2/2/1928 Director 83 MA Usual Residence of Deceden 28a-f show 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1x Yes 2 No MD Worcester Ocean City 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10000 Coastal Hwy. Unit 1507 28142 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 ☐ Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Auditor US Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eunice A. Moulton Burton Lawrence Sawyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000519a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Laurie Evelyn Born/daughter 5390 Hillgate Crossing, Johns Creek, GA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Walnut Cemetery 9/10/2011 Haverhill, MA 21. Signature 22. Name and Address of Facility Burbage Funeral Home Funeral Service L 108 William St., Berlin, MD 21811 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ng physician and as the burial-transit that initiated events resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 9 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) signed by the a g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law rewithin 24 hours after death.

To the Euneral Director: After this certificate has be completed filled in by the funeral director. prior to completion of cause of death? performed? 1 Ves 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဂ္ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation pleted filled in by the 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my calcium. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 128 2011 D34593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 Nicholas Ogburn 100 E. Carroll St. Salisbury, Md. 21801 31. Date filed (Month, Day, Year) State AUG 30 Registrar

11-06777 Amanda Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 29588 State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar				Certifica	ate of	Death					eg. No.			
Physicia		Decedent's Name (First,	Middle,Last	t)								Date of Dea Month		Year		of Death
edical Exami	ner	Amanda	Nicol	e Smit	h							Septemb	er 8, 2011	, 50.	040)3 hrs
		4a. Facility Name (if not in:					4	b. City, To	wn, or Lo	ocation of	Death		4c. Cou	nty of Dea	ith	
		Railroad Crossing						Ellersli	е				Alleg	any		
		5. Social Security Number	6. Se			yrs. last birt	hday)	If Under	1 Year	If Under	24Hrs.	8. Date of Bi	rth(MM/DD/Y	YYY) 9. E	irthplace ((State or
Funeral Director								Months	Days	Hours	Min.	12/22	/1992	Fore		Maryland
Director		218-37-8008		M 2 X F	18		Yrs.	<u> </u>			<u> </u>	12/22/	1002			i az j zarra
		Usual Residence of Deced			1100	City, Town	or Locatio	\n_							10d. In	side City Limits
' any	- 1	10a. State 10b. C						711							1 X	Yes 2 No
nd show	늘	MD AI	legan	У		Ellers	тте									
Aaryland 28a-f show 1 at once.	헔	10e. Street and Number						10f. Zip 0				10g. Citizen of Wha			ountry?	
th the M. 23a or 2	Director	10414 Red M	aple	Lane				2	21529	9		1	U.S	. A.		
ith th		11. Marital Status			ecedent Ever	in U.S.	13. Was	Deceden	t of Hisp	anic Origi	in? (Spec	ify Yes or N				ian, Black,
th w	Funeral	1 X Never Married 2	Married	Armed	Forces?		If Y∈	s, specify	Cuban,	Mexican,	Puerto Ri	ican, etc.)	'	White, etc.		
r death or iter	교	3 Widowed 4		1 Yes If Yes, Give Ye	2 X	No	1	Yes 2	No.	specify:			Spec	cify: V	Mite	
s afte	Š	15. Decedent's Education	_	or Dates:		ad) 16a		's Usual O			ind of wor	rk done	16b. Kind	of Busines	s/Industry	
hour natu Exan	ompleted				(1-4 or 5+)		during mo	st of work	ing life. I	TON OC	use retired	d)				
6 1 72 E	흦	Elementary/Secondary	0-12)	2	(1-4 01 5+)		C+-	udent						Educa	tion	
vithii ene.	Ē	12					اد	daeiic		8 Mother's	s Name (r	irst Middle	Maiden Surr	name)	-	·
Hygging the	ပ	17. Father's Name (First, I							- 1"				ine (M		z) Sm	ith
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Timothy So				1140		Address	/011				ımber, City or			
ould Me	P	19a. Informant's Name/Re														
MD d 2 sho Ith and n 27 is		Timothy So		<u>mith</u>	Fath	er]	L0414	Red	Map	le La	ane,	Eller Date	slie,	tion City	or Town	State
e, l l and Heal item	1	20a. Method of Disposition		Пъ		20b. Place	tory or oth	er place)		- 1			1			State
10re, MD 21215-0036 sges I and 2 should be filed within 72 hou nt of Health and Mental Hygiene. It If tiem 27 is marked other than "nat other traumatic event, the Medical Exa		1 XBurial 2 Cre			from State	Rest]	Lawn	Mem.	Gar	dens	09/1	12/201	l LaV	ale,	MD	
t. Partmer		4 Donation 5 0	ner Specify	r. nsee									neral			P.A.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mannal Hygerian and The Health and Mannal Hygerian Engorates. If these Traumatic of ther than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once	l I	21. Signature of Turiers	. / /	nchw	101								ale, M			
		23a. Part I. Enter the dise	- U	plications that	caused the	death Don	ot enter th	e mode of	dvina. s	such as ca	ardiac or r	espiratory a	rrest, shock,	or heart	Appr	roximate Interval
Physician		failure. List only one	cause on ea	ach line.		doddii. Do ii	0. 0		- ,g,						Betv	ween Onset and Death
/Medical Examiner		Immediate Cause (Final o		Multiple Ir										_	-	
_xammer		or condition resulting in d	eath)	Due to (or as	a conseque	ence of):										
		Sequentially list condition				6)			_		_				_	
	Examiner	if any, leading to immedia cause. Enter Underlying	Cause	Due to (or as	a conseque	ence of):										
	E	(Disease or injury that init	ateu C.	Due to (or as	a conseque	ence of):										
scuted and transit	ШÄ	events resulting in death)	d.													
760, cate be executi physician and he burial - trai	ledical	UNPENDED			28d,p	er me	, g919	9-2	6-11	sm						
50, te be exe ysician a	ğ			27,280	l,per_	me,g9	20 10) <u>–25–</u>	11 s	m			23d D:	ate of deliv	verv	
760, ficate be g physic the burn	₹	IF FEMALE: 23b. Was decedent pregna	nt in the	1 Live	s, outcome o	r pregnancy	′ o∏ Fe	tal death	3	Ectopic	pregnan	су	Mo		Day	Year
ox 68 sath certifi attending for use as	iğ.	past 12 months?			gnant at time			her (Spec								
Box 68 e death certif the attending ed for use as	Sic	1 Yes 2 No 9	Unknow	n 9 Uni	known		о <u> </u>	Hel (open	,				1			_
that the denet by the detached is	Physician	Part II. Other significant	conditions	contributing	to death bu	t not resultir	ng in the u	ınderlying	cause g	iven in Pa	art I.	23e. Did	tobacco use	contribute	to the cau	use of death?
that the detay												1 🗌 Y	es 2 🗸 No	о 3 <u> </u> Г	robably	4 Unknown
ords, P w requires to as been signed	Completed by						_					24a. Wa	is an	24b. Were	autopsy f	findings available
v required should	호											aut	opsy formed?	prior death		tion of cause of
CO ie lav ie ha: ge 2	Ę											1 Yes		1		2 No
tal Rec cian: The certificate ector, page		25. Was case referred to	medical						26.Place	of Death	(Check or	nly one)				
ician ician s cert recto		examiner?	- 1	Hospital:	Inpatient	2 FR/0	Outpatient	3 D	OA T	Other ₄	Nursing	Home 5	Residence	6 V 0	ther: Scen	ne
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rather death. The and Director. After this certificate has been signed by led in by the funeral director, page 2 should be deated.	ြို	1 Yes 2	10	28a Da	te of Injury		. Time of		8c. Injur	y at Work	?	28d. Describ	e how injury	occurred (subjec	t-stepped
ling Ph	Ë	1 Natural 5	Pending		nth, Day,Year) , 2011		56 hrs	· ·	1 \(\)	'es 2 ✓	No I		cp onto u	eomine	train (onto for-comino
ior frend leath for:	ag:	2 X Accident	Investiga	tion							= 4	Crain S	ubject	Str.	Rural Ro	oute Number, City
ViS or A fter of Direction by	≝	3 Suicide 6	Could no	t be	lace of Injury	- At home,	farm, stre	et, factory,	оптсе в	uliaing, ei		or Tours	State			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bundal - transi	Certification:	4 Homicide	determin	(1000)	fy) Railro						-		ossing at SI	_		- IND
Hosi 24 ho Fun		29a. Certifier 1 Certi	ying Physic	clan: To the b	oest of my kr	nowledge, d	eath occu	rred at the	time, da	ate and pla	ace, and	due to the ca	ause(s) and m	nanner as	stated.	eo(s)
To the Hospital within 24 hours To the Funeral completely fille	<u>i</u> ë	one) 2 Medi	al Examine	er: On the bas	is of examin	ation and/or	investiga	tion, in my	opinion	, death o	ccurred at	the time, da	ite and place,	and due t	o the caus	se(s)
To wit	Medical	29b. Signature and title of	certifier		. o.u.ou.			290	. Licens	e number			29d. Dat	e signed	(Month, D	ay, Year)
	1	Qual	c						O.C.I	M.E.			Septe	mber 8,	2011	
4)		CVVQ-ZC				h //4 00 :	\				·					
34		30. Name and address o	person who	o completed c ant Medica	ause of deat	n (item 23a) or OOO) \// ₽≈!-	imore 9	Street	Raltimo	ore MD	21223				
0		Ana Rubio MD.		A				annote c	,,, cc,	Jakinik						
	State		(Year)	32.	Registrar'	signature	Mal									
Regi	stra	2 SER T 9	LU11	Lenger	~ /V.	7										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#4a & 4b permit FCHD IM 8/29/11

State of Maryland / Department of Health and Mental Hygien 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 26, 2210 P M Merhle Thomas Tucker August 2011 Medical 4a. Facility Name (if not institution, give street and number)
Shady Grove Adventist Hospital 4b. City, Town, or Location of Peath: 11e 4c. County of Death **Examiner** 26824 Ridge Road Damascus 1 4 1 Montgomery 8. Date of Birth
(Month, Day, Year)
April 27,1929 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Maryland Days Min 1 M 2 D F Months Yrs **Director** 220-30-9027 82 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No <u>Maryl</u>and Montgomery Damascus ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be 23a Funeral must 20872 26824 Ridge Road items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ■ No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done duning most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Food Industry Butcher Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Tucker Thelma Zucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise M. McCoy, Daughter 6207 Monioe Avenue, Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 29, 2011 Alexandria, Virginia 21. Signature of Fun va Service Licenses 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, MD 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death aspiration pheumonia Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of): Examiner acute renal tallure Sequentially list conditions, Examine Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury failure and I-transit chronic renal or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last the burialattending physician potension Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by obstructive pulmonar disense 1 Yes 2 No 3 Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed? death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO-O-Dillege MD DD 0 66 456 August 27, 2011 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Median Center Drive, Rockville, Maryland 20850 9901 Pakeye Oluwapelumi 31. Date filed (Month, Day, Year) AUG 29 201 32. Registrar's Signature State Registrar

Y

N

75/201

August

RHUE

10

7

FUCKER

1	1-0651	0
Ε	dward	Terry

lease Type or Print in Black Indelible Ink	:. Ensure All Copies Are Legible. 2 リー	ナ
State of Maryland / Department of H	lealth and Mental Hygiene	

		1- For State Registrar		Cer	tificate d	of Death			F	Reg. No.			
Physici		Decedent's Name (First, Mide	Middle,Last) Edward Lee Terry, Jr.						2. Date of De	3.	Time of Death		
Medical Exami			Lee Terry						Month August 2	Day 9 2011	Year		0718 hrs
1		4a. Facility Name (if not instituti				4b. City, Town, or	Location of	Death	guot 2	4c. County of Death			
		3417 Orange Grove	-			Ellicott City					ward		l
				12 A //				0.411	To Date -45			District.	one (State or
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. ia	ast birthday)	If Under 1 Yea Months Day	_	Min.	Fore			oreign	
Director		212-86-3884	1 M 2 F	47	Yı	Yrs. Months Days Flours Min. Aug 17			On onter it		() MD		
	-	Usual Residence of Decedent	1						F 2019	, ,	× 1		
Any		10a. State 10b. County	1	10c. City,	Town or Loca	ation			_			100	d. Inside City Limits
. å		MD 11		1	D11'							1	Yes 2X No
Aaryland 28a-f show <u>1 at once,</u>	٥	MD HON	ward		EIII	Cott City				10g. Citizer	n of What	Country	,
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must, be notified at once.	Director								1	rog. Citizei	II OF WINAC	Country	
the the		3417 Orange G	rove Court	-		210	43			Ur	nited	l Sta	tes
with	uneral	11. Marital Status		cedent Ever in U.		vas Decedent of His				lo- 14			Indian, Black,
death w or items	튁	1 Never Married 2 1	Married Armed F	orces?	lf lf	Yes, specify Cubar	i, Mexican, I	Puerto I	Rican, etc.)		White, e	etc.	
ier d	ᄣ	3 Widowed 4 O	ivorced If Yes, Give Ye	er 2 100	1	Yes 2K No	specify:			S	pecify:	Whit	e l
rs af	٥	15. Decedent's Education (Sp	or Dates:		16a. Decede	ent's Usual Occupa	tion (Give ki	ind of w	ork done	16b, Kin	d of Busin	ess/Indu	stry ,
hou Ers	Completed	Elementary/Secondary (0-12		1-4 or 5+)		most of working life				Apos	d of Busin	.oori	ng/
72 n 72	흥	10	College	140131)	т.	nstaller					Const		don
5-003(led within tygiene. other the	Ĕ				11	iscarrer	40.14-15-1-	N	(First 14 dalla			<u> Luct</u>	.1011
Hyg Hyg		17. Father's Name (First, Middle		a					(First, Middle				
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	å	Edward Lee		Sr.				viar		Crabi		_	
Ould Me	리	19a. Informant's Name/Relation			1.0	ng Address (Stree							
MD d 2 should the and and 27 is summati		Barbara J. Ten	rry/wife		3417	Orange G	rove (Ct	Ellico	ott Ci	ity,	MD 2	1043
and and item		20a. Method of Disposition				osition (Name of ce	metery,		Date	20c. Lo	cation - C	ity or Tov	n, State
Ses 1 For Her right		1 Burial 2 Crematic	on 3 🦳 Removalit	OIII Glate	crematory or o			0/0	/0011	1			1
Pag ment		4 Donation 5 Other 5		φοοc		nerd Ceme							ty, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", e injury or other traumatic event, the Medical Examiner.	- 1	21. Parature of Funeral Service	e Lisensee										y, F.H. In
© 80 8 ©	- 1	Juanita K	thomas			112 01d C							MD 21043
Physician		23a Part I. Enter the disease, o	or complications that	caused the death.	Do not enter	the mode of dying,	such as ca	rdiac or	respiratory a	rrest, shock	c, or heart	1000	pproximate Interval Between Onset and
/Medical	ļ	failure. List only one caus Immediate Cause (Final disease)	e on each line. Mu	rtipre ar	us tox	icity inv	olvin	g me Oxv	codome	ie, Alp	razo	Tann d	Death
Towns and the con-			TICLIE	ama Le. Zo.	Thrasm	· · · · · · · · · · · · · · · · · · ·				400		100	
£xaminer	- 1	Immediate Cause (Final diseas or condition resulting in death)	e a. Ono 11	a consequence of	ararac	· diffatati	on		· ·	450		-	
£xaminer		or condition resulting in death)	Due to (or as	a consequence of	959195 959195	'diTafati	ŌΠ		·	450		+	· ·
£xaminer	<u>_</u>	or condition resulting in death) Sequentially list conditions,	Due to (or as	a consequence of	f):	'diTatati	ōn		·	450		1	
£xaminer	iner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as b. Due to (or as	a consequence of	f):	'ATTERNET	Ön		·	450		1	
	taminer	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as b. C.	a consequence of	f): f):	,4178F3F1	Ön		·				
d sit	Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as b. C.	a consequence of	f): f):	,4178EHE1	On		·				
d sit	cal Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c. Due to (or as d.	a consequence of	f): f):								
executed an and al - transit	edical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED	Due to (or as b. Due to (or as c. Due to (or as d.	a consequence of a consequence of a consequence of $1,230,27$	n: n: n: n: ME G9	28°10767							
executed an and al - transit	/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENUED 23c. If yes	a consequence of a consequence of a consequence of $\frac{1}{2}$, $\frac{23}{1}$, $\frac{27}{2}$, outcome of pregi	f): f): ME G9 nancy	28°107575	919 9 11 TT	-27	-11 sm	23d. l	Date of de	alivery	Year
executed an and al - transit	/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE:	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENDED the 1 Live	a consequence of a consequence of a consequence of $\frac{1}{2}$, $\frac{23}{1}$, $\frac{27}{2}$, outcome of pregi	f): f): f): f): f): f): f): f(): f(): f(20°107675	919 9 11 TT	-27	-11 sm	23d. l			Year
executed an and al - transit	/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months?	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENUED the 1 Live 4 Preg	a consequence of a consequence of a consequence of #1.23a,27 #1. Der outcome of pregulation and at time of de	f): f): f): f): f): f): f): f(): f(): f(28°107575	919 9 11 TT	-27	-11 sm	23d. l	Date of de	alivery	Year
executed an and al - transit	/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causi (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Universely	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENUED the large of the larg	a consequence of a consequence of a consequence of \$\frac{1}{230},\frac{27}{per}\$, outcome of pregion outcome of denown	7): 7): 7): 7): 7	20°10767° Fetal death 3 Other (Specify)	919 11 TT	i – 27 pregnar	-11 sm	23d. I	Date of de	alivery Day	
executed an and al - transit	Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causi (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months?	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENUED the large of the larg	a consequence of a consequence of a consequence of \$\frac{1}{230},\frac{27}{per}\$, outcome of pregion outcome of denown	7): 7): 7): 7): 7	20°10767° Fetal death 3 Other (Specify)	919 11 TT	i – 27 pregnar	-11 sm	23d. M	Date of de lonth se contribu	Day	cause of death?
P.O. Box 68760, so that the death certificate be executed gned by the attending physician and edeached for use as the burial - transit	by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causi (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Universely	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENUED the large of the larg	a consequence of a consequence of a consequence of \$\frac{1}{230},\frac{27}{per}\$, outcome of pregion outcome of denown	7): 7): 7): 7): 7	20°10767° Fetal death 3 Other (Specify)	919 11 TT	i – 27 pregnar	-11 sm	23d. M M tobacco us	Date of deflorth	Day	cause of death?
P.O. Box 68760, so that the death certificate be executed gned by the attending physician and edeached for use as the burial - transit	by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causi (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Universely	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENUED the large of the larg	a consequence of a consequence of a consequence of \$\frac{1}{230},\frac{27}{per}\$, outcome of pregion outcome of denown	7): 7): 7): 7): 7	20°10767° Fetal death 3 Other (Specify)	919 11 TT	i – 27 pregnar	-11 sm	23d. M M tobacco us	Date of deflorith	Day ute to the	cause of death? y 4 Unknown sy findings available
P.O. Box 68760, so that the death certificate be executed gned by the attending physician and edeached for use as the burial - transit	by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causi (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Universely	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENUED the large of the larg	a consequence of a consequence of a consequence of \$\frac{1}{230},\frac{27}{per}\$, outcome of pregion outcome of denown	7): 7): 7): 7): 7	20°10767° Fetal death 3 Other (Specify)	919 11 TT	i – 27 pregnar	23e. Did	23d. M tobacco us es 2 tobacco us es an oppsy formed?	Date of de lonth se contribu No 3	Day Day The to the Probable re autoport to compath?	cause of death? y 4 Unknown sy findings available oletion of cause of
P.O. Box 68760, so that the death certificate be executed gned by the attending physician and edeached for use as the burial - transit	by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un Part II. Other significant cond	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENCED the 1 Live 4 Pregnknown 9 Unkr	a consequence of a consequence of a consequence of \$\frac{1}{230},\frac{27}{per}\$, outcome of pregion outcome of denown	7): 7): 7): 7): 7	20°107676	Ectopic	pregnar	23e. Did 1 Y 24a. Wa aut per 1 Yes	23d. M M tobacco us es 2 2 1	Date of de lonth se contribu No 3	Day Day Probable autops or to component to	cause of death? y 4 Unknown sy findings available
P.O. Box 68760, so that the death certificate be executed gned by the attending physician and edeached for use as the burial - transit	Completed by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un Part II. Other significant cond	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENUE) the 23c. If yes 1 Live 4 Pregnknown 9 Unkr	a consequence of a consequence of a consequence of a consequence of 1,23a,27,7,72er, outcome of pregion outcome of pregion and at time of denown to death but not respectively.	f): f): ME G9 nancy 2	20 10 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6	Ectopic Given in Par	pregnar	23e. Did 1 Y 24a. Wa autu 1 Yes	23d. M tobacco us ses 2 1 1 s an opsy formed? 2 No	Date of defloring the contribution of the cont	Day Ite to the Probable re autoport to compath?	cause of death? y 4 Unknown sy findings available oletion of cause of 2 No
Vital Records, P.O. Box 68760, ssician: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit	o Be Completed by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un Part II. Other significant cond	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENCED the 1 Live 4 Pregnknown 9 Unkr	a consequence of a consequence of a consequence of \$\frac{1}{230},\frac{27}{per}\$, outcome of pregion outcome of denown	7): 7): 7): 7): 7	20 10 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6	Ectopic Given in Par	pregnar	23e. Did 1 Y 24a. Wa aut per 1 Yes	23d. M tobacco us ses 2 1 1 s an opsy formed? 2 No	Date of defloring the contribution of the cont	Day Ite to the Probable re autoport to compath?	cause of death? y 4 Unknown sy findings available oletion of cause of 2 No
Vital Records, P.O. Box 68760, ssician: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un Part II. Other significant cond	Due to (or as b. Due to (or as c. Due to (or as d. X. AMENDED the 1 Live 4 Pregnknown 9 Unkritions contributing	a consequence of a consequence of a consequence of a consequence of 1,232,27,471,0err, outcome of pregion birth mant at time of denown to death but not related to the following the fol	f): f): ME G9 nancy 2	20° 10767° Fetal death 3 Other (Specify) a underlying cause of the control of	Ectopic Given in Par	pregnar	23e. Did 1 Y 24a. Wa autu 1 Yes	23d. M tobacco us es 2 s an opsy formed? : 2 No	Date of deflorith Se contribution 24b. We price dear the price of which the price of which the price of the	Day Day Probable re autopor to compath? Yes Other: Sc	cause of death? y 4 Unknown sy findings available oletion of cause of 2 No
of Vital Records, P.O. Box 68760, ag Physician: The law requires that the death certificate be executed wher this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causi (Disease or injury that initiated events resulting in death) Last WUPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Ui Part II. Other significant cond 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per	Due to (or as b. Due to (or as b. Due to (or as c. Due to (or as d. X. AMENDED the 1 Live 4 Pregnknown 9 Unkritions contributing labeled the labeled t	a consequence of 1,23a,27,41a, per outcome of pregulation of the nown to death but not really the pay, year)	f): f): ME G9 nancy ath 5 (26 Place 26 Place 26 Place 26 Place 26 Place 17 3 DOA 16 Injury 28c. Inju	Ectopic Siven in Par of Death (pregnar	23e. Did 1 Y 24a. Wa auto per 1 Yes only one) g Home 5	tobacco us es 2 1 1 s an opsy formed? 2 No Residence	Date of deflorith Se contribution 24b. We price dear the price of which the price of which the price of the	Day Day Probable re autopor to compath? Yes Other: Sc	cause of death? y 4 Unknown sy findings available oletion of cause of 2 No
of Vital Records, P.O. Box 68760, ag Physician: The law requires that the death certificate be executed wher this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causi (Disease or injury that initiated events resulting in death) Last WUPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Ui Part II. Other significant cond 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per Inv	Due to (or as b. Due to (or as b. Due to (or as d. AMENDED the 1 Live 4 Pregnknown 9 Unkritions contributing 28a. Date anding estigation fd 8 28e. Pla	a consequence of a consequence of a consequence of a consequence of 1,232,27,471, per control of per control of the nown to death but not reconstruct the control of the nown to death but not reconstruct the control of the nown to death but not reconstruct the control of the nown to death but not reconstruct the nown to death but nown	f): f): f): ME G9 nancy ath 5 (20°107676 Fetal death 3 Other (Specify) a underlying cause of the second and th	Ectopic Ectopic given in Par of Death (Other ry at Work?	pregnar ttl.	23e. Did 1 Y 24a. Wa auto per 1 Yes volution on 3 Home 5 28d. Describe 1nknown	tobacco us es 2 1 No s an opsy formed? s 2 No Residence how injury	Date of deflorith Se contribution No 3 24b. Wee prior dear 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Day Day Probable autop: or to compath? Yes Other: So	cause of death? y 4 Unknown sy findings available oletion of cause of 2 No seene
of Vital Records, P.O. Box 68760, ag Physician: The law requires that the death certificate be executed wher this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un Part II. Other significant cond 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per Inv	Due to (or as b. Due to (or as b. Due to (or as d. Z. AMENUE) the 23c. If yes 1 Live 4 Pregnknown 9 Unkritions contributing Hospital: 1 28a. Date (Montributing estigation uld not be	a consequence of 1,23a,27,47. Det 7, outcome of pregion of the nown to death but not result to death but n	f): f): f): ME G9 nancy ath 5	26 Place 26 Place 26 Place 26 Place 26 Place 17 3 DOA 16 Injury 28c. Inju	Ectopic Ectopic given in Par of Death (Other ry at Work?	pregnar	23e. Did 1 Y 24a. Wa auto per 1 Yes volume 5 28d. Describe 28d. Describe 28f. Location or Town,	tobacco us es 2 1 No s an opsy formed? Residence how injury 10 (Street and State) 3 4	Date of deforth Se contribution No 3 24b. We prior dear 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Day Day Probable re autopor to compath? Yes Other Scoon Rural	cause of death? y 4 Unknown sy findings available oletion of cause of 2 No
of Vital Records, P.O. Box 68760, ag Physician: The law requires that the death certificate be executed wher this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transit	o Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un Part II. Other significant cond 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per Inv 3 Suicide 6 Coodet	Due to (or as b. Due to (or as b. Due to (or as d. AMENDED 1 Live 4 Pregnknown 9 Unkritions contributing 28a. Date (Moning estigation uld not be ermined 28e. Pla	a consequence of per publish mant at time of de nown to death but not receive of Injury and the consequence of Injury and Injury an	ER/Outpatier 2 Fd 6:3 ome, farm, str	20 107676 Fetal death 3 Other (Specify) a underlying cause of the second and th	Ectopic Gother Tanger at Work? Yes 2 X building, etc.	pregnar	23e. Did 1 Y 24a. Wa autu yers 1 Y 28d. Describu 11 known 28f. Location or Town, Ellico	tobacco us es 2 1 no s an opsy formed? 2 No Residence e how injury n (Street and State) 3 4	Date of deflorith Le contribution of the cont	Day Ite to the Probable re autopor to compath? Other: So Or Rural ange	cause of death? y 4 Unknown sy findings available oletion of cause of 2 No seene
of Vital Records, P.O. Box 68760, ag Physician: The law requires that the death certificate be executed wher this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Unit of the past 12 months? Part II. Other significant conditions of the past 12 months? 25. Was case referred to medic examiner? 1 Yes 2 No 2 No 27. Manner of Death 1 Natural 5 Per Inv. Accident Inv. 3 Suicide 6 Cook det 29a. Certifier (Check only) Certifying I Certifying I	Due to (or as b. Due to (or as b. Due to (or as d. AMENDED the 23c. If yes 1 Live 4 Pregnknown 9 Unkritions contributing 28a. Date (Monday estigation uld not be ermined 28e. Pla (Specify Physician: To the be	a consequence of per outcome of pregration and at time of de nown to death but not result in the consequence of a consequence	ER/Outpatier 28b. Time of dence ge, death occe	20 107676 Fetal death 3 Other (Specify) a underlying cause of the second of the seco	Ectopic Ectopic of Death (Other	pregnar	23e. Did 1 Y 24a. Wa auto per 1 Yes only one) 9 Home 5 28d. Describe 1nknown 28f. Location or Town, Ellico due to the ca	tobacco us es 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Date of deflorith Lee contribution 24b. We printed the printed t	Day or Rural ange os stated.	cause of death? y 4 Unknown sy findings available oletion of cause of 2 No sene Route Number, City C Grove Ct.
of Vital Records, P.O. Box 68760, ag Physician: The law requires that the death certificate be executed wher this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causi (Disease or injury that initiated events resulting in death) Last WUPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 University of the past 12 months? 1 Yes 2 No 9 University of the past 12 months? 25. Was case referred to medic examiner? 1 Yes 2 No 9 University of the past 12 months? 27. Manner of Death 1 Natural 5 Per 2 Accident Invaluation of the past 12 months of	Due to (or as b. Due to (or as b. Due to (or as d. Due to	a consequence of 1,232,27 per outcome of pregion of the prown to death but not result to	ER/Outpatier 28b. Time of dence ge, death occe	20 107676 Fetal death 3 Other (Specify) a underlying cause of the second of the seco	Ectopic Ectopic of Death (Other	pregnar	23e. Did 1 Y 24a. Wa auto per 1 Yes only one) 9 Home 5 28d. Describe 1nknown 28f. Location or Town, Ellico due to the ca	tobacco us es 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Date of deflorith Lee contribution 24b. We printed the printed t	Day or Rural ange os stated.	cause of death? y 4 Unknown sy findings available oletion of cause of 2 No sene Route Number, City C Grove Ct.
of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and nurral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Unit of the past 12 months? Part II. Other significant conditions of the past 12 months? 25. Was case referred to medic examiner? 1 Yes 2 No 2 No 27. Manner of Death 1 Natural 5 Per Inv. Accident Inv. 3 Suicide 6 Cook det 29a. Certifier (Check only) Certifying I Certifying I	Due to (or as b. Due to (or as b. Due to (or as d. Due to	a consequence of 1,232,27 per outcome of pregion of the prown to death but not result to	ER/Outpatier 28b. Time of dence ge, death occe	20 107676 Fetal death 3 Other (Specify) a underlying cause of the second of the seco	Ectopic Ectopic of Death (to Other 4	pregnar	23e. Did 1 Y 24a. Wa auto per 1 Yes only one) 9 Home 5 28d. Describe 1nknown 28f. Location or Town, Ellico due to the ca	tobacco us les 2 1 les s an opsy formed? 2 No Residence how injury 11 (Street and State) 3 4 tt Ci use(s) and te and place	Date of deflorth Se contribution No 3 24b. We print dear 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Day Day Day Day Day Day Day Day	cause of death? y 4 Unknown sy findings available oletion of cause of 2 No sene Route Number, City C Grove Ct.
of Vital Records, P.O. Box 68760, ag Physician: The law requires that the death certificate be executed wher this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un Part II. Other significant cond 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 No 27. Manner of Death 1 Natural 5 Per 2 No 28. Certifier 1 Certifying 10 Certifyin	Due to (or as b. Due to (or as b. Due to (or as d. Due to	a consequence of 1,232,27 per outcome of pregion of the prown to death but not result to	ER/Outpatier 28b. Time of dence ge, death occe	26 Place and and property and	Ectopic Ectopic of Death (i Other 1 ry at Work? Yes 2 X ate and place ate and pl	pregnar	23e. Did 1 Y 24a. Wa auto per 1 Yes only one) 9 Home 5 28d. Describe 1nknown 28f. Location or Town, Ellico due to the ca	tobacco us es 2 1 1 s an opsy formed? 2 No Residence e how injury n (Street anc State) 3 4 tt Ci use(s) and te and place	Date of deflorth Se contribution No 3 24b. We print dear 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	probable or Rural and Cange of the cange of	cause of death? y 4 Unknown sy findings available pletion of cause of 2 No seene Route Number, City ause(s)
of Vital Records, P.O. Box 68760, ag Physician: The law requires that the death certificate be executed wher this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un Part II. Other significant conditions are in past 12 months? 25. Was case referred to medic examiner? 1 Yes 2 No 2 No 27. Manner of Death 1 Natural 5 Per Inv Accident Inv 3 Suicide 6 Cook det Underly one) 2 Medical Ex 29a. Certifier (Check only one) 2 Medical Ex 29b. Signature and title of certifying Inv Accident Inv Accident Inv One) 2 Medical Ex	Due to (or as b. Due to (or as b. Due to (or as d. AMENUED 1 Live 4 Pregnknown 9 Unkritions contributing 28a. Date (Moning estigation uld not be ermined (Specify Physician: To the besiment on the basis and manner for the property of the carmined (Specify Physician: To the besiment on the basis and manner for the property of the prop	a consequence of per out of the consequence of a consequence of the consequence of a conseq	ER/Outpatien ER/Outpatien 28b. Time of fd 6:30 ome, farm, str dence ge, death occ and/or investig	20 107676 Tetal death 3 Other (Specify) a underlying cause of the second of Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 29c. Licens	Ectopic Ectopic of Death (i Other 1 ry at Work? Yes 2 X ate and place ate and pl	pregnar	23e. Did 1 Y 24a. Wa auto per 1 Yes only one) 9 Home 5 28d. Describe 1nknown 28f. Location or Town, Ellico due to the ca	tobacco us es 2 1 1 s an opsy formed? 2 No Residence e how injury n (Street anc State) 3 4 tt Ci use(s) and te and place	Date of delonth Se contribution 1 24b. We price deal 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	probable or Rural and Cange of the cange of	cause of death? y 4 Unknown sy findings available pletion of cause of 2 No seene Route Number, City ause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un Part II. Other significant cond 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per Inv 3 Suicide 6 Cood detailed of the condition one) 29a. Certifier 1 Certifying (Check only one) 29b. Signature and title of certifying the condition of the certifier of the certifier one) 29b. Signature and title of certifying the certifier of the certifier one of the certifier one) 20. Name and address of personal conditions and the certifier of the certifier one of the certifier of the certifier one of the certifier one of the certifier of the certifier of the certifier one of the certifier of the certifier one of the certifier	Due to (or as b. Due to (or as b. Due to (or as d. AMENUED 1 Live 4 Pregnknown 9 Unkritions contributing 28a. Data (Moning estigation et al (Specify Physician: To the basis and manner for who completed call the contribution who completed call the	a consequence of per outcome of pregration and at time of definition of the consequence of the consequence of Injury - At here	ER/Outpatier ER/Outpatier 28b. Time of d 6:3 ome, farm, str dence ge, death occ nd/or investig	26 Place 26 Place a underlying cause of the second of Injury 28c. Injury 29c. Licens 29c	Ectopic Description in Par of Death (to Other 1	pregnar	23e. Did 1 Y 24a. Wa autu pers 1 Y 28d. Describe 11 known 28f. Location or Town, F11ico due to the ca	tobacco us ses 2 1 No ses 2 No Residence e how injury (Street and State) 3 4 tt Ci use(s) and te and place Augu	Date of delonth Se contribution 1 24b. We price deal 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	probable or Rural and Cange of the cange of	cause of death? y 4 Unknown sy findings available pletion of cause of 2 No seene Route Number, City ause(s)
of Vital Records, P.O. Box 68760, ag Physician: The law requires that the death certificate be executed wher this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un Part II. Other significant cond 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per examiner? 2 Accident Inv 3 Suicide 6 Cooded 4 Homicide 29a. Certifier 1 Certifying Cone) 2 Medical Ex 29b. Signature and title of certifying Cone (Check only one) 2 Medical Ex 30. Name and address of person Victor Weedn MD JE	Due to (or as b. Due to (or as b. Due to (or as d. Due to	a consequence of pregration and a time of definition and a consequence of	ER/Outpatien ER/Outpatien 28b. Time of d 6:3 ome, farm, str dence ge, death occ nd/or investig 123a) mer 900	20 107676 Tetal death 3 Other (Specify) a underlying cause of the second of Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 29c. Licens	Ectopic Description in Par of Death (to Other 1	pregnar	23e. Did 1 Y 24a. Wa autu pers 1 Y 28d. Describe 11 known 28f. Location or Town, F11ico due to the ca	tobacco us ses 2 1 No ses 2 No Residence e how injury (Street and State) 3 4 tt Ci use(s) and te and place Augu	Date of delonth Se contribution 1 24b. We price deal 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	probable or Rural and Cange of the cange of	cause of death? y 4 Unknown sy findings available pletion of cause of 2 No seene Route Number, City ause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un Part II. Other significant cond 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per Inv 3 Suicide 6 Cood detailed of the condition one) 29a. Certifier 1 Certifying (Check only one) 29b. Signature and title of certifying the condition of the certifier of the certifier one) 29b. Signature and title of certifying the certifier of the certifier one of the certifier one) 20. Name and address of personal conditions and the certifier of the certifier one of the certifier of the certifier one of the certifier one of the certifier of the certifier of the certifier one of the certifier of the certifier one of the certifier	Due to (or as b. Due to (or as b. Due to (or as d. Due to	a consequence of per outcome of pregration and at time of definition of the consequence of the consequence of Injury - At here	ER/Outpatier 28b. Time of dence ge, death occ nd/or investig	26 Place 26 Place a underlying cause of the second of Injury 28c. Injury 29c. Licens 29c	Ectopic Description in Par of Death (to Other 1	pregnar	23e. Did 1 Y 24a. Wa autu pers 1 Y 28d. Describe 11 known 28f. Location or Town, F11ico due to the ca	tobacco us ses 2 1 No ses 2 No Residence e how injury (Street and State) 3 4 tt Ci use(s) and te and place Augu	Date of delonth Se contribution 1 24b. We price deal 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	probable or Rural and Cange of the cange of	cause of death? y 4 Unknown sy findings available pletion of cause of 2 No seene Route Number, City ause(s)

Certificate of Death

2. Date of Death Month

25

Year

Prince George's

2011

4c. County of Death

U.S.A.

Specify:

14. Race - American Indian,

White

Black White, etc.

Education

 A^{M}

10:00

9. Birthplace (State or Foreign Country)
New Jersey

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 🔼 No

Physician Irving Wasserman August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mitchellville Collington Episcopal Life Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 20, Social Security Numbe 7. Age (In yrs. last birthday) ^{Year)}1926 **Funeral** Days 148-12-8811 1**X** M 2 □ F Months Hours 85 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exominer must be retilled at once. Mitchellville Maryland Prince George's Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20711 10450 Lottsford Road, #221 Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-if Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes. Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: ò of Yes, Give Year or Dates:1946–48 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) College Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dora Schwartz Harry Wasserman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adam Wasserman/son 240 Hillside Circle Vienna, Virginia 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2XX remation 3 ☐ Removal from State Baltimore Crematory 8/30/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Buneral Solvice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 121 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and ise as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. sate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dostructure

28a. Date of Injury (Month, Day, Year)

and manner stated.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

29d. Date signed (Month, Day, Year)

23d. Date of delivery

Month

24a. Was an autopsy perform 1 □ Yes

Were autopsy findings available prior to completion of cause of 1 ☐ Yes 2 ☐ No

Vear

26. Place of Death (Check only one) Other: 4 Landursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

8116 Good Luck Rd., #300 Lanham, Maryland

D25079

29c. License number

State

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

To the Hospital within 24 hours a To the Funeral C

of Vital Records.

Division

Completed by

Be

မ

Certification:

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

100 12000

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manne of Death

2 Accident

4 Homicide

1 Natural

3 Suicide

29a. Certifier

1. Decedent's Name (First, Middle, Last)

AUG 2 9 2011

Don Yablonowitz, MD

5 ☐ Pending investigation

6 ☐ Could not be

determined

32. Registrar's Signature park

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 29592 For State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month DEUEL VERLOUS WINCHESTER 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1921 LARKHAIL RD. BALTIMORE UNDALK **Funeral** Age (In vrs. last birthday) (Month, Day, Year) 8. Date of Birth Birthplace (State or Foreign Country) If Under 2 1 M 2 D F Hours Min Director N.C 28a-f show 10a State must be notified at 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE 1 Yes 2 No UNDALK 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country items 23a Funeral 921 LARKHAILRD 21222 ر S. A. death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Black, White, etc. "natural", or 3 Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: 3 ₩idowed 4 Divorced Completed Specify WHITE Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
It is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) the CARINET CO ABINET MAKER Be Department of Health and Mental Hy Important if Item 27 is marked any injury or other 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ NORA ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4216 SPRING AVE. HALETHORPE, MD. 21227 DANIE WINCHESTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CARRET - HILLCRES 4 ☐ Donation 5 ☐ Other (Specify) -14-11 WAYNSYITE, N.C. 22. Name and Address of Facility DaughERTY FUNCES HOME Signature of Fyneral Service Licen-2601 MOUNTAIN 400942 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximate** Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Premone moure Medical Examiner Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 2 No signed by the 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ congestive heart failure, pementis Completed page 2 should 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Director: After this certificate I performed' Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 4 No Other: 유 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 2 Acciden
3 Suicide Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD DOOTOLE35 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel Bulkmore, MD 4105 State Registrar

Please Type or Print in Black Indelibled ny Ensure All Sopies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 29593 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 10:09 A M Elsie W. Yanchulis 28, 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 302 W. Edmonston Drive Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Hours Min. 579-26-4293 **Director** 86 May Pennsylvania Usual Residence of Decedent Fshow the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 302 W. Edmonston Drive 20852 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 X Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: Caucasian Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked Vernon Washabaugh Minnie Boyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter F. Yanchulis, Spouse 302 W. Edmonston Drive, Rockville, Maryland 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or c 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Crematory 8/31/2011 Brentwood, Maryland Signature of Funeral Service Licensee MO1102 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Lung Cancer mos Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Due to (or as a consequence of): and I-ramsir requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are use as the burialburial-Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy atter for u in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Y Unknown Completed 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law ate has page 2 s autopsy performed? death? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 \square Yes 2 🗶 No Other: ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director. After thi completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0061083 August 30, 2011 30. Name and page person who completed cause of death (Item 23a) (Type, Print)

State Registrar Paul Tanbi,

31. Date filed (

Month, Day, Year, AUG 3 1

. Registrar's Signa

9707 Medical Center Drive, Suite 300, Rockville, Maryland 20850

Albrecht George

				e or Print in I						
		4	For State Registrar	tate of Marylan		ariment of r tificate of L		/	Reg. No.	29594
	Physicia		1. Decedent's Name (First, Middle, Last) George J. Albi	echt Sr.				2. Date of Dea Month		3. Time of Death
	Medic Examin	_	4a. Facility Name (if not institution, give street			4b. City, Town, or	r Location of Death	1	4c. County of Deat	h
1			Frank In Square 5. Social Security Number 16. Sex	1105 Pita	at histhday)	ROSE d	O_ C If Under 24 Hrs.	8. Date of Birth	Baltiv	norc hplace (State or Foreign
	Funeral Director		216-30-0321 1X M	2 🗆 🗆	7 Yrs.	Months Days	Hours Min.	(Month, Day Dec. 1	; Year) Co.	MD
	aryland a-f show fied at	Director	10a. State 10b. County MD Baltimore	1	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛛 No
	vith the M 23a or 28 st be noti	ral Dir	10e. Street and Number 509 N. Woodward	Drive		10f. Zip Code 2122	21		10g. Citizen of What Co	ountry?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	1 Never Married 2 Married	Vas Decedent Ever in U.S \(\text{Immed Forces} \)? \(\text{Immed Yes} \ 2 \) \(\text{M} \) No forces \(\text{Yes} \ \ \text{Give} \) \(\text{Year or Dates} \).		Was Decedent of H If Yes, specify Cuba 1 Yes 2 Xo	lispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
21215-0036	thin 72 hour sne. than "natu ne Medical	Completed	1 . 1	on mpleted) College (1-4 or 5+)	(Give life. D	dent's Usual Occup kind of work done O NOT use retired) L neer	during most of worki	ng	16b. Kind of Business Bectal P Corporat	ower
d 2	filed wi al Hygie I other vent, tl	Be	12th 17. Father's Name (First, Middle, Last)				18. Mother's Name			
Maryland	uld be Menta narked natic e	우	Adolph F. Albre						offman	- 0- 4-1
, Mai	nd 2 shoreseth and no 27 is neer traum		19a. Informant's Name/Relationship (Type, F Helen Albrecht		19b. Maili 509	N . Woo	odward D	rive B	r, City or Town, State, Zi altimore	MD 21221
Baltimore,	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)			osition (Name of matory or other place S OI Fa		Date 17/11	20c. Location - City or Rossvill	
Balt	permit. Departr Import any inj		21. Signature of Fineral pervice Unit	groully !	h 2	2. Name and Addre	3	00 Mac	e Ave. Ba	lto. MD
	h, ician/ Medical Examiner		23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one call mmediate Cause (Final disease or condition resulting in death)	ons that caused me deat use on each line.	nia	er the mode of dyir	ng, such as cardiac (or respiratory arr	rest,	Approximate Interval Between Onset and Death
00	executed an and rial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underl in Cause (Disease or iinjury that initiated events resulting in death) Last b. – b. – c. – d. –							
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director. After this certificate has been signed by the attending physician and Funeral in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medica	in the past 12 months?	If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of 5 Unknown	al death 3	Ectopic pregnan Other (specify) _	icy		23d. Date of do Month	elivery Day Year
s, P.O.	res that t signed b d be deta	d by P	Part II. Other significant conditions contrib Metastatic Pa				iven in Part I.		obacco use contribute t	o the cause of death? Probably 4 Unknown
Division of Vital Records,	The law require cate has been si ; page 2 should I	Complete						1 🗌 Yes	psy prior to ormed? death?	utopsy findings available completion of cause of
/ital	/sician s certif director	To Be	25. Was case referred to medical examiner? 1 Yes 2 N No	ital: 1 ☐ Inpatient 2 🛣	ER/Outpatie		Place of Death (Chec her: 4 \Bursing H		dence 6 Other (Spe	cify)
Jo (ling Phy n. Vfter thi funeral o		1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time o injury	of 28c. Inju	ry at		now injury occurred	
ivisior	or Attend after death Director: / in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif				28f. Location (S City or Tov	Street and Number or R vn, State)	ural Route Number,
Ω	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 was completed filled in by the funeral director, page 2 was a first of the funeral director.	Medical	(Chock 2 Medical Evaminer	n: To the best of my know On the basis of examination actioner: To the best of m	n and/or inve	stigation, in my opin	ion, death occurred a	at the time, date a	and place, and due to the	e cause(s) and manner stated
	To the within 2 To the comple	2	29b. Signature and title of certifier	WHAT		29c. Licen:			29d. Date signed (Mon	
			1000	and a super a Call and the	n 00cl /7:		4670		9-14-11	
6	V		30. Name and address of person who comp	,			quare Dr	ve Ba	Itimore m	10 21237
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 6 2011	32. Registrar's Signa		Ker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month FORMBER 10 Year N Physician/ Richard B. Atchison Medical County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE CLEH BURNIE BAKTIMBRE INDSHINGTON MEDICAL 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) 8 Date of Birth **Funeral** 12/01/37/1915 1**X**XM 2 □ F Days 95 348-10-6735 Tllinois Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a, State at Director Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2XXNo Severn Marvland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21144 Funeral 704 Northwood Estates 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Black White etc. 1 Never Married 2 Married 1 Yes ZXX No þ 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2√√ No Specify: Completed 3 ★ Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Florida Health Department Environmental Inspector Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myrtle Ward ٥ Clarence Atchison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 704 Northwood Estates, Severn, Maryland 21144 James Atchison / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory or other place Sept.13,201 Glen Burnie, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 21. Signature of Funeral Service Licensee 7250 Washington Blve., Elkridge, Maryland ,21075 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER METASTATIZ Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ☐ Pregnant. ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Certificate: To Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital: 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Mann of Death 28c. Injury at 1 Natural 5 Pendina within 24 hours after death.

To the Funeral Director; Af completed filled in by the fu 1 🗆 Yes 2 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

DHMH 17 Rev 7/2009

10 94

(Check

only one)

31. Date filed (Moηth,

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a)(Type, Print)

Tryp

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10.2011

11-06523 Donnie Brewer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onnie Brewer		State of Maryland		artment of		and	Menta	al Hyg		2	01	1 29591
Physic Medical Exam	ian/	1. Decedent's Name (First, Middle,Last) Donnie Brewer							Date of Dea Month August 29	th	Year	3. Time of Death 1801 hrs
		4a. Facility Name (if not institution, give street and number)			b. City, Tov	vn, or Lo	ocation of I		August 29	4c. Cou	nty of Dea	
Funeral	F	Union Hospital 5. Social Security Number 6. Sex 7. Age	e (In yrs. I	last birthday)	Elkton If Under	Year	If Under 2	24Hrs.	8. Date of Bir	Cecil		irthplace (State or
Director		222-36-9322 1 _M M ₂ D _F	58	Yrs.	Months	Days	Hours	Min.		4/195	3 Fore	ountry) MD
any		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Locati	on							10d. Inside City Limits
E	Ö	MD Cecil		Elkto	n							1 Yes 2 No
ne Mary or 28a- ified at	Director	10e. Street and Number 1824 Blue Ball Road			10f. Zip Co	ode 2192	21		1	0g. Citizen o	f What Co	untry?
h with ti ems 23a t. be. noti	uneral	11. Marital Status 12. Was Decedent	Ever in U			of Hispa	nic Origin		ify Yes or No	- 14. R	ace - Ame	erican Indian, Black,
iter deat	F	3 Widowed 4 X Divorced If Yes, Give Year	X No		Yes 2			ueito Ki	cail, etc.)	Spec	vhite, etc. _{ifv} . Wh	nite
hours at rastural Examin	ed by	1 or Dates:		16a. Decedent		cupation	n (Give kin			16b. Kind o		s/Industry
036 ithin 72 ne. r than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5	+)	_	Body	_			•	A	uto	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens and Maryland Important. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be Co	17. Father's Name (First, Middle, Last) Anbus Brewer	-	1	<u> </u>	18.			irst, Middle, M acksoi		me)	
212 Ould be id Ment is mark tic even	TO B	19a. Informant's Name/Relationship (Type, Print)					nd Numbe	er or Rur	al Route Num	ber, City or		
and 2 sho lealth and ten 27 is traumati	1	Tricia Maxey Niece 20a. Method of Disposition	20b. i	1342 Place of Disposi					e Nap			1 1 0 3
Baltimore, permit. Pages I at Department of Hec Important: If ite		1 Burial 2 Cremation 3 Removal from Star 4 Donation 5 Other Specify:		crematory or oth lantic		n		9/7	/11			nie MD
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Licensee		1.	ame and Ad							Fun Serv
Physician		23a. Part I. Enter the disease, or complications that caused to failure. List only one cause on each line.	he death	Th . Do not enter th	omas/ e mode of d	$\frac{11}{\text{ying, su}}$	en PA	70 liac or re	90 Riespiratory arre	dge R est, shock, or	d Ha	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atheroscle Due to (or as a consection)			ovasc	ulaı	r Dis	ease	2			Between Onset and Death
	L	Sequentially list conditions, b.										
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated										
executed an and al - transit		events resulting in death) Last Due to (or as a consect d.		•	1355 (6)							
sici	edical	▼ UNPENDED			919 9	-19-	-11 sı	m				
Box 68760, death certificate be ex the attending physician of for use as the burial.	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcomed 1 Live birth		2 Feta	al death	з 🗌	Ectopic pr	egnancy	/	23d. Date Month	of delive	ry Day Year
Box te death of the atten	Physician/M	1 Yes 2 No 9 Unknown Pregnant at ti	me of de	ath 5 Oth	er (Specify)							
P.O. s that the gned by	Š	Part II. Other significant conditions contributing to death	but not re	esulting in the ur	iderlying ca	use give	en in Part I.				_	the cause of death?
cords, P.O. law requires that the has been signed by	Completed							_	24a. Was a	ın 24	b. Were a	utopsy findings available
Reco The law icate has	Somp							_	autops perfor 1 Yes 2	med?	death?	completion of cause of
Vital Rec hysician: The I this certificate I	å	25. Was case referred to medical examiner?	2 🗸	ER/Outpatient			Death (Ch		one)	Pasidanca	3 Othe	V.
	n: To	27. Manner of Death 28a. Date of Injun (Month, Day,Yer	,	28b. Time of In	ury 28c.	Injury a	it Work?	28	d. Describe h			
'SiOr Attener er death rector:	Catic	2 Accident Investigation	ırv - At ho	ome, farm, street			2 No		f Location (S	treet and Nu	mber or R	ural Route Number, City
Div spital or nours aft neral Di filled ir	Certification:											
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of exam	knowledg ination ar	ge, death occurre nd/or investigation	ed at the tim on, in my opi	e, date a nion, de	and place, eath occuri	and due	e to the cause e time, date a	e(s) and man and place, an	ner as sta d due to t	ted ne cause(s)
5 W 5 00	¥	29b. Signature and title of certifier			29c. Lie	cense ni	umber			29d. Date s	gned (Mo	onth, Day, Year)
		30. Name and address of person who completed cause of de	ath /Item	23a)	°	.C.M.E	E			August 3	0, 2011	200
0	9	Ling Li, MD Assistant Medical Examiner	900 \	W. Baltimore	Street, I	3altim	ore, MD	2122	3			10
St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Registrar's	Signatu		wer							

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29597 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bulleit 2011 4:42 P M Jeanne Sept Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery <u>Suburban Hospital</u> If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2XX Months Days Hours (Month, Day, Washington D.C Director 85 1926 579-32-9739 June Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland ns 23a or 28a-f sho must be notified at Director Montgomery 1 🗆 Yes 2 💢 No Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 9707 Old Georgetown Rd. 20814 #2207 United States iral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 🔀 No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give White "natural" 3 XWidowed 4 Divorced Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Elementary School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Fitem 27 is marked of other traumatic ever ပ Horace Parsley Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Bulleit, Jr. 6722 Selkirk Court, Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 09/14/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) INRACEREBRAL HEMORRHAGE (NON TRAMATIC) Medical Due to (or as a consequence of): Examiner COAGULAPATHY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 \(\sum \) Yes 2 \(\bar{X} \) No Day Year Month Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 I IInknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2X No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Yes 2 X No in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DQA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No X Natural iniury 5 Pending Accident Investigation or Attendation of the death Director; 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Hospital of 24 hours at Funeral D Medical 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the second of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Confining Number Planting States of the cause of the time date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

11/0

TUNG NGOC DAO M.D., 6410 ROCKLEDGE DR. #200, BETHESDA, MD

30. Name an ordress of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Den Year)

06177 a

9/13/11

20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For & 10 eState of Maryla State Registrar		tificate of De			Reg. No 2 0	1 29598	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death O832 A M	
	Medic Examin	al	Melvin Glenn Bohrer 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. County of		
أسب	Examili	er	Western Maryland Health Syst	tem	Cumber:			Alle		
	Funeral Director		233-78-4935 ^{1 ⊠ M 2 □ F} 61	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Oct 4,	1949	9. Birthplace (State or Foreign Country) Pennsylvania	
	laryland Sa-f show ified at	1 1		City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
	with the N s 23a or 24 ust be not	Funeral Director	10e. Street and Number 127 Polk Street 4/8 Coethe Street; Apt 2		10f. Zip Code 21502			10g. Citizen of What Country? USA		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ठ्	11. Marital Status 1 Never Married 2 M Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 14. Was Decedent Ever in Armed Forces? 15. Was Decedent Ever in Armed Forces? 16. Was Decedent Ever in Armed Forces? 17. Was Decedent Ever in Armed Forces? 18. Was Decedent Ever in Armed Forces?		Nas Decedent of Hisp f Yes, specify Cuban, □ Yes 2 🛣 No		cify Yes or No- Rican, etc.)		- American Indian, k, White, etc. white	
215-0	nin 72 hour ne. than "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I	dent's Usual Occupat kind of work done du O NOT use retired)		ng	16b. Kind of Bu	siness Industry	
Baltimore, Maryland 21215-0036	oe filed with intal Hygier ced other to s event, th	l as l	17. Father's Name (First, Middle, Last) Melvin Glenn Bohrer	d1:	sabled	18. Mother's Nam Virgini	e (First, Middle, a Coffn	Maiden Surname,)	
Mary	12 should the and Me 27 is mark		19a. Informant's Name/Relationship (Type, Print) Margaret Bohrer - wife	19b. Mailin	Address (Street and Polk St.) Coethe	nd Number or Rura Ceet Street; 1	Pt 2;	r, City or Town, St	tate, Zip Code)	
more,	Page 1 and 2 seems of Health seems of Health and 1 inter 27 inter vary or other tra			b. Place of Dispo cemetery, cren	sition (Name of natory or other place,		Date	20c. Location -	City or Town, State	
Balti	permit. F Departm Importa any inju		21. Sign to of Figeral Sense Licensee	tor,	2. Name and Address	of FacilitySta altimore	te Anato St; Ba	omy Boar ltimore,	d MD 21201	
	Pnysician/ Medical Examiner		23a. Pan 1. Enter the disease, or complications that caused the dishock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Output Due to (or as a condition or		er the mode of dying,		or respiratory an	rest,	Approximate Interval Between Onset and Death	
1760	cate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consulting in death) Last Due to (or as a consulting in death) Last							
	To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ If Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	te of delivery nth Day Year	
s, P.O	iires that th signed by Id be deta		Part II. Other significant conditions contributing to death but not Huper Hellicus	t resulting in the L	underlying cause give	en in Part I.			ribute to the cause of death? 3 Probably 4 Unknown	
Division of Vital Records,	The law require ate has been s page 2 should	Completed by	Hyper tessan Deabetes melleters I	7		-	24a. Was auto perfo 1 Yes	psy prmed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
ta	sician; The certificate rector, pag	Be	25. Was case referred to medical examiner?		26. Pla	ce of Death (Chec	k only one)			
n of Vi	ding Physi h. After this c funeral din	cate: To	1 Ves 2 No 1 Nonpatient 2 27. Manner of Death 1 Natural 5 Pending (Month, Day, Year Accident Investigation	28b. Time o	nt 3 □ DOA f 28c. Injury work?	4 ☐ Nursing Heat		dence 6 Other		
Divisio	al or Attending I s after death. Il Director: After d in by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe		reet, factory, office		28f. Location (City or Tou		er or Rural Route Number,	
_	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my kr 2 **Medical Examiner: On the basis of examination only one) 3 **Certifying Nurse Practioner: To the best of the basis of examination only one) 1 **Certifying Nurse Practioner: To the best of the basis of examination only one) 1 **Certifying Nurse Practioner: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one) 1 **Certifying Physician: To the basis of examination only one 1 **Certifying Physician: To the basis of examination only one 1 **Certifying Physician: To the basis of examination only one 1 **Certifying Physician: To the basis of examination only one 1 **Certifying Physician: To the basis of examination only one 1 **Certifying Physician: To the basis of examination only one 1 **Certifying Physician: To the basis of examination on 1 **Certifying Physician: To the basis of examination on 1 **Certifying Physician: To the basis of examination on 1 **Certifying Physician: To the basis of examination on 1 **Certifying Physician: To the basis of examination on 1 **Certifying Physician: To the basis of examination on 1 **Certifying Physician: To the basis of examination on 1 **Certifying Physician: To the basis of examination on 1 **	ation and/or inves	stigation, in my opinior death occurred at the	n, death occurred a time, date and pla	it the time, date	and place, and due ne cause(s) and ma	e to the cause(s) and manner stated anner as stated.	
	To the within 2 To the comple		29b. Signature and title of certifier BULMD		29c. License	number 66101		29d. Date signed 9/12/1	d (Month, Day, Year)	
			30. Name and address of person who completed cause of death (ABOUL HANAN HEEMA 31. Date filed (Month, Day, Year) SEP 1 6 2011 32 Registrar's Si	Item 23a) (Type, I	Print) Willow	w broo	K Ro	o ceer	nborland m021502	
	Sta Registr		31. Date filed (Month, Day, Year) 32/Registrar's Si	ignatus.	arked					

		•	1 - State Registrar	Ji iviai yiai i	-	tificate of L	Death		Reg. No.	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) RICHARD Z. GANA	SZAK				2. Date of Dea		2011
	Examin	er		PARE S	ystem	PI	Location of Death	NT	4c. County	of Peathe / L
	Funeral Director		5. Social Security Number 208-28-1322 Usual Residence of Decedent	7. Age (In yrs. Ia:	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov • 18	, 1938	9. Birthplace Country) PA
	and show d at	ior	10a. State 10b. County	10c. City	, Town or Loc	ation	<u> </u>		_	10d. lr
	th the Maryland 3a or 28a-f show t be notified at	Director	MD Harford	Ве	1 Air					1
	n with the is 23a or nust be r	Funeral D	10e. Street and Number 1456 Landis Circle			10f. Zip Code 21015			10g. Citizen of V USA	Vhat Country?
9800	1 and 2 should be filed within 72 hours after death with the Manyland f Health and Mental Hyglene f Health and Mental Hyglene item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 Ă Married 1 Ā Arged F 1 컵 Yes Gi Year or D	2 □ No ive	lf.	/as Decedent of H Yes, specify Cuba ☐ Yes 2 🛣 No	ispanic Origin? (Spanic Origin? (Spanic Origin), Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Inc ck, White, etc. White
1215-(hin 72 ho ne. than "nat ie Medica	Completed		1-4 or 5+)	(Give ki life. DC	NOT use retired)	during most of work	ing		usiness Industry
d 2	filed within 7 tal Hygiene. ed other than event, the M	ادہ ا	17. Father's Name (First, Middle, Last)		неттс	opter Pi	18. Mother's Nam	e (First, Middle, I		
ylan	should be file n and Mental H is marked o raumatic eve	욘	Jake Banaszak				Leona I	Rich		
, Mar	and 2 shoul Health and I tem 27 is m		19a. Informant's Name/Relationship (<i>Type, Print</i>) Mary Banaszak (Wife)				and Number or Rura Sircle, Be			State, Zip Code)
=			20a. Method of Disposition 1 ☐ Burial 2 XXC remation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State ce	ametery, crem lantic	ition (Name of atory or other place Cremato	ry 09/1	.2/11		urnie,
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Fungral Service Licensee)			^{ss of Facility} Sch Phail Roa			
Į	Physician/ Medical		23a. Part 1. Ent. the disease, or complications that shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death)	ach line PLE	Seh	the mode of dyin	g, such as cardiac o	or respiratory arr	est,	App Inte
	Examiner		Due to	(or as a conseque	ence of):					
	p #	Examiner	cause. Enter Underlying	(or as a our secur	anna cfjr					
	ath certificate be executed attending physician and for use as the burial-transit	al Exan	Cause (Disease or linjury that initiated events c	(or as a conseque	ence of):	<u>.</u>				
8760	cate be	Medical	d							
Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	I 7	in the past 12 months?	atcome of pregnar e Birth 2 Fetal gnant at time of do known	death 3 🗌	Ectopic pregnand Other (specify)	су			ate of delivery onth Day
P.O.	that the ned by e detac	by Ph	Part II. Other significant conditions contributing to	death but not resu	ulting in the ur	nderlying cause gi	ven in Part I.	23e. Did to	bacco use cont	ribute to the ca
rds,	een sig oould b	eted						1 🗆 ነ	Yes 2 □ No	
Reco	The law requires that the de sate has been signed by the page 2 should be detached	Completed			_			24a. Was a autop perfor	rmed?	Were autopsy fi prior to comple death? 1 ☐ Yes 2 ☐
Ital	iician; The certificate rector, pag	Be	25. Was case referred to medical examiner?			26. Pl	ace of Death (Chec	k only one)		
of <	y Phys er this c eral dir	e: 10	27. Manner of Death 28a. Date		28b. Time of	28c. Injur	4 LA Nursing Ho yat	ome 5 Resid		
.≥	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	nth, Day, Year) e of Injury - At hor ling, etc. (Specify)	injury me, farm, stre		(? Yes 2 □ No	28f. Location (S City or Tow	Street and Numb	er or Rural Rou
	Hospital 24 hours a Funeral I	Medical	29a. Certifier (Check Check University) 1 Certifying Physician: To the be to the control of the	asis of examination	and/or investi	gation, in my opinie	on, death occurred a	t the time, date a	nd place, and du	e to the cause(s
	To the within 2 To the comple		29b. Signature and title of certifier	TO THE OWN CELLY	w.comogo, o	29c. Licens	e number		29d. Date signe	
9	A. 70		· / /				051739		Sept	10, 20
7	KIN)		30. Name and address of person who completed cat SURESK SHANDELYA,	se of death (Item	9 MARY	LAND HE	12A3 HTJA	SYSTE	M, PERF	Y POINT,
	Stat Registra	ır	31. Date filed (Month, Day, Year) 6 2011	www j	9. Asa	ale				

20c. Location - City or Town, State Glen Burnie, MD k Funeral Home, Bel Air 21014 Air, MD Approximate Interval Between On Attand Death 23d. Date of delivery Month Day Year id tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? /as an utopsv erformed? es 2 \ No 1 🗌 Yes 2 🗆 No esidence 6 🗌 Other (Specify) be how injury occurred in (Street and Number or Rural Route Number, cause(s) and manner as stated. ite and place, and due to the cause(s) and manner stated. the causals) and manner as stat 29d. Date signed (Month, Day, Year) Sept. 10, 2011 TEM, PERRY POINT, MD 21902

29599

3. Time of Death

9. Birthplace (State or Foreign Country)
PA

10d. Inside City Limits 1 🗆 Yes 🏋 No

14. Race - American Indian, Black, White, etc. White

Please Type or Print in Black Indelible Ink From All Property Are Legible per FH Amend 14 per FH, 24ab per med ceff Legible per FH State of Maryland / Department of Health and Mental Hygiene AMEND TEM#20a, b, per FH, C920, 10, 572011, WS For State Registrar 9600 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Sentember BRE HON 18.47-P.M Physician/ SHIRLEY 2011 Medical County of Death City, Town, or Location of Death la. Facility Name (if not institution, give street and number, Examiner more ands 4 down 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 23 Yrs. Month Day 19338 Country) 1 □ M 2 🗹 Months Director Decedent 10d. Inside City Limits City, Town or Location or 28a-f shov 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No ston 10g. Citizen of What Country? 10e. Street and Number Funeral 23a permit. Page 1 and 2 should be filed within 72 hours after death with 21/33 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner muronce. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1. Marital Status Black, White, etc. Black þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, ၉ Edwards 19b. Mailing Address (Street and Number or Rural Route Number, Informant's Name/Relationship (Type, 20a. Method of Disposition

1 Durial 2 Cremation 3 20<u>c. L</u>ocation - City or Town, State 20b. Place of Disposition (Name of certain, cremato vor other place) Removal from State Limore, MD 4 ☐ Donation 5 ☐ Other (Specify) reene Funeral Services Signal re of Funeral Service Lice 23a. Part 1. Enler the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical 1446 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by CEREBROVASCULAR DISEASE 1 Tes 2 No 3 Probably 4 Unknown META BOLIC 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL 24a. Was an HYPERTENSION ENCEPHLOPATH autopsy performed? FIRRILLATION 1 ☐ Yes 2 🕱 No 1X Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Medical Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 29d Date signed (Month, Day, Year) September 3 29c. License number 0 5 4 2 8 8 29b. Signature and title of certifier 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPINE CONTER Rangonogan MORTHWEST Kamaswary I 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State SEP 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13, September Physician/ 6:18 P M Sherry Madeline Barr Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 1515 Grange Road Street 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Funeral NOV • 12 Days Hours 1 🗆 M 2 🕮 F 217-62-7355 58 Director Usual Residence of Deceden 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 72 hours after death with the Maryland Director 1 Tes 2 No Maryland Harford Street 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 1515 Grange Road 21154 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2X Married ρ Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give and Mental Hygiene. White 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.] 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Education Teachers Aide Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fern (nmn) Walter Arthur Ray Barker Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1515 Grange Drive, Street, Maryland 21154 Grady C. Barr / Husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2X Cremation 3 Removal from State Hilltop Service Corp. 9-19-2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sign up of Fungal Service Licensee Mar 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final nd Strye ren Due to (or as a consequence of) ₽nysician/ disease or condition resulting in death) End renal Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No Year Month Day Pregnant at time of death 1 ☐ Yes 2 ≥ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Myocardial infarction, Hypertension 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypercholesterolemia autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 1 M Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 20c. License number 12011

State Registrar

SEP 1 6 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aly Naguib

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Bu shweck Phie September 12,2011 10:10P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Long View Nursing Home Manchester Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛣 F 122-03-5889 93 July 1,1918 New York Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Carroll Manchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3332 Main Street 21102 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 Is marked other the any Injury or other traumatic event Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Tyminski Mary Prusnowski ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 340 Bonnie Meadow Circle, Reisterstown, Maryland21136 Michael Bushneck 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Assumption Cemetery 9-17-11 Syracuse.New_York 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses michael marcullo 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** evelvo rasculy /Medical Due to (or as a consequence of) Examiner Mercusclisit Esque flairy liet our diffunc, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician The law requires that the death certificate be Physician/Medical the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 20 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 24 hours after death. e Funeral Director; After this completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2 To the I 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

(Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23b, 24b, per phy, g919 9-16-11 sm State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Balloc eptember Physician/ 201 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOPKINS Johns Himore HOSPIta If Under 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numb **Funeral** July 12, Year) 1971 Hawaii 1 M 2 XF Months Hours Min. 045-74-8052 40 Yrs **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at rector Maryland Anne Arundel Brooklyn 1 Tes 2 No Ö 10f. Zip Code 10e. Street and Number Citizen of What Country? United States Funeral 5313 Wasena Avenue 21225 of America death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 filed within 72 hours after 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Menta! Hygiene. ?7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Administrative Medical Billing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Thomas J. Balloch Maureen Kavanaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Thomas J. Balloch/ father 5530 Foxhall Court Frederick, Maryland 21703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September cemetery, crematory or other place)
Evans Funeral
apel- Bel Air 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12, 2011 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Service Licenses Perent Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Exter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Legatic enysician/ disease or condition resulting in death) Medical Due to (or as a contequence of Examiner Hepatitis C Infection Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a pensioning of ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burners. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 X Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV 1000 N. Wolfe St. Baltimore MD 21287 Elga min 32. Registrar's Signature Month, Day, Year State 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 29604 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Day Year Physician/ 201 500 0 ce Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hora Greenspring 8. Date of Birth (Month, Day, If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 LF Months Days Hours Min Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Yes, 2 \ No timore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 21211 eenspring Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Walte mitt adv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philadelphia Baltimore, 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) timore Furreral Service Lic 22. Name and Address of Facility 21. Signati MD nts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCAR Ph_i ian/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): HTERIOSC cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform Yes 2 No 1 ☐ Yes 2 🔏 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital 1 Tyes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29d. Date signed (Month) Day, Year) who completed cause of death (Item 23a) (Type Printy, BELVEDERE AVE. Name, and address of person

State

Registrar

William Isiah Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-06752 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day September 7, 2011 1250 hrs Medical Examiner William Isaiah Brown 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore N/A3301 S. Hanover Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs, last birthday) 5 Social Security Number 6. Sex **Funeral** oreign Months Days Hours Country) Ma<u>ryland</u> Director 02/02/1986 1X M 2 F 25 216-11-6872 Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 No 28a-f show N/ABaltimore Maryland , or items 23a or 28a-f shor must be notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4009 Orchard Avenue 21225 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 Married Yes Black 4 Divorced If Yes, Give Year Specify: 3 Widowed 1 Yes 2 No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 2 Student Schoo1 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Isaiah Johnson, Jr. Vashti Gwen Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vashti Gwen Brown-Bryant/Mother 3205 Gulfport Drive, Baltimore, Maryland 21225 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Metro Crematory Inc. 09/14/2011 Baltimore, Maryland Donation 5 Other Specify 21. Signature of Funeral Service Licensee Alyson~K~Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 Approximate Interval 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Immediate Cause (Final disease Drowning ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that I Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tran Physician/Medical X UNPENDED AMENDED 1 as noted,23a,27,28a-f per me g920 10-13-11 vt Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Vear 3 Ectopic pregnancy Month 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical å examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28d. Describe how injury occurred subject seen 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury jumping from bridge into water Natural 1 Yes 2 X No 5 Pending Director: d in by the f fd 12:16am fd 9-7-11 and subsequently drowned 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3301 S. Hanover St. Baltimore, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide Could not be S. Hanover St. Baltimore, determined water behind harbor hospital Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated.

OCME 2006

30. Name and address of person who completed cause

Theodore M. King, Jr., MD.

29b. Signature and title of certifier

death (Item 23a)

29c. License number

O.C.M.E.

Assista Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

OCME

29d. Date signed (Month, Day, Year)

September 8, 2011

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Dapartment of Health and Mental Hygiene

1 - State amend#24aperverb g919 9-29-11 Certificate of Death

Reg. No. 2 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Sont Sont 1653 Physician/ 2011 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner saltimore tospita amaritan 6. Sex 1 M 2 □ F . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Number **Funeral** (Month, Day, Months Days Hours Min. Year 39 Missouri 32-275 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location at 10a State Director must be notified Yes 2 No 17 more 10g. Citizen of What Country? 10f. Zip Code ò 10e. Street and Number 23a Funeral 21201 trank items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. o 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Army Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NQT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) filed within al Hygiene. nion the elder other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Department of Health and Important: If item 27 is m any injury or other traums 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) stella Frankford Aug Hout more, MD 21264 20c. Location - Çity or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of emetery crematory or other place) Burial 2 🗌 Cremation 3 🗌 Removal from State Burial 2 U Cremation 4 Donation 5 Other (Specify) saltimoe. Edneral Service Lice owell 22. Name and Address of Facility -uneral uan MD 21213 rehm altimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE MYOCARDIAC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner b. ATHEROSCLEFOTIC CAPDIOVASCUL Sequentially list conditions. Examine Due to or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit and that initiated events Due to (or as a consequence of): resulting in death) Last the burial physician Physician/Medical Division of Vital Records P.O. Box 68760 as attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Unknown 2 No the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PENAL 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No certificate has autopsy performed? Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 2 ER/Dutpatient 3 DOA ျာ 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 9,201 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 21239 LOCH RAVEN 5601 BALTIMORE, MD TOSEPH M.D. BUYD KERITH 31. Date filed (Month, Dev, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 7:45PM Medical entember 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death tim 1zab. ursina ent 8. Date of Birth (Month, Day, Year) May 1, 1924 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 M M XX New York **Director** 87 22-18-7611 Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If fiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Baltimore XIX Yes 2 I No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 Benson Ave. 21227 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes XXNo Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify 3 Widowed WDivorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) School Bus Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles William Jackett Florence Anna Kendall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14529 Dover Rd. Reisterstown, Christine Shriver/Daughter MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or oth All Faiths 1 Burial XXCremation 3 Removal from State 4 ☐ Donation 🔊 ☐ Other (Specify) Manchester, MD <u>9/16/11</u> Signature of Superal Service I censee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any hading to immedia cause. Enter Underlying Cause (Disease or iinjury and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burnal-transit MI that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ____ Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DO Medical Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD enue 31. Date fileb (Month, Day, Year) 32. Regist State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 29608 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JAMES CARTER 2011 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE -AUREL REGIONAL HOSPITAL AUREL GEORGES Social Security Number If Under 24 Hrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Min Month, Day, 035-22-0379 ani **Director** 6 Usual Residence of Deceden 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10d. Inside City Limits Director Examiner must be notified MORE 1 Yes 2 No 0 10e. Street and Number 10g. Citizen of What Country Funeral 23a amers DILLE items 12. Was Decedent Ever in U.S. Armed Forces 1 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced er than "natur , the Medical B 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) avag rocer Department of Health and Mental Hygies Important: If item 27 is marked other i any injury or other traumatic event, th once. Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden မ acter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, KWY Pati Method of Disposition 20b. Place of Disposition (Name of 20c. Location -2011 Signature of Funeral Service Licentee . How larviand 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ schemic disease or condition resulting in death) Medical **Examiner** etabolic Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last pronary the burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical ena Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖊 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the A only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ٩ D41248 101

Registrar

State

Laurel Regional Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

. Okango,

I

George

Van Dusen Road

MD

7300

Laurel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #31 Per PHY G919 9/16/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.20 29609 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 13, 2011 8:15amM Ρ. James Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 35 Pendragon Court Reisterstown If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours Min (Month, Day, Year, Country) 1 X M 2 - F Vrs **Director** 61 212-50-7358 Usual Residence of Decedent fshow 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Examiner must be notified at **Funeral Director** 1 Yes 2 No 28a-1 MD **Baltimore** Reisterstown o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a U.S.A 21136 35 Pendragon Court permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married "natural", or 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: White Completed 3 ☐ Widowed 4 🂢 Divorced Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
amply or other traumatic event, the Medical J
one. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tile Tile Setter 10 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eleanor Marie Dukes James William Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pikesville, MD 4765 Bonnie Brae Road Connie Noto Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD 9/21/11 Garrison Forest Vet 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 11824 Reisterstown Road Reisterstown, MD 21136 ELINE FUNERAL HOME Approximate Interval Between Onset and Death 2 a. Pa 1. Enter the disease, or complication the caused the Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on eac Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last ng physician as the burial-Physician/Medical Rospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes ≥ t 9 ☐ Unknow P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Was an 24a. autopsy performed' 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c Injury at 28d. Describe how injury occurred Certificate: Natural Accider injury work? 5 Pending 1 ☐ Yes 2 ☐ No Ascident Investigation Director: / Accident

Suicide

Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner within 2 To the I only one) 29b. Signature and title of 30. Name and dress eath (Item 23a) (Type, Print) 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State OT IV	laryland / Der Ce	ertificate of D			2011	29610							
	Physicia		1. Decedent's Name (First, Middle, Last) David Drumm				2. Date of Death Month Septembe	er 14, 201	3. Time of Death							
	Medic Examin		4a. Facility Name (if not institution, give street and number) 2800 Hillcrest Avenue		4b. City, Town, or L			4c. County of Dea	th							
	Funeral Director			ge (In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye June 12,	9. Bir	chigan							
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. San or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10b. County MD Baltimore	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 🛛 No							
		Funeral Director	10e. Street and Number 2800 Hillcrest Avenue		10f. Zip Code 21234		10g	g. Citizen of What C								
980	rs after death ural", or items Examiner mu	þ	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces 1 □ Yes 2 V If Yes, Give Year or Dates.	Ever in U.S. 13	B. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 X No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	te, etc.							
215-0	in 72 hou e. nan "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	(Giv life.	16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind											
nd 21	filed with al Hygien d other th	Be	17. Father's Name (First, Middle, Last)	Softv		18. Mother's Nam	e (First, Middle, Mai	den Surname)	<u> </u>							
Aaryla	should be and Ment is marke raumatic	J.	Bruce Carl Drumm 19a. Informant's Name/Relationship (Type, Print) Dorrothy, Drumm/wijfe	nd Number or Rura	rgianna Mehrhoff er or Rural Route Number, City or Town, State, Zip Code) en or Parkyillo MD 21234											
Baltimore, Maryland 21215-0036	age 1 and 2 int of Health t: If item 27 or other t															
Baltin	permit. Pa Departme Importan any injury once.		21. Signature of Funeral Service Licensee		22. Name and Address	of Facility Crematic	n Service	P.O. B	ox 784							
44	[⊵] h₌sician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heardfailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Bladder Cancer Due to (or as a consequence of):													
	Medical Examiner		resulting in death) Due to (or a Sequentially list conditions,	s a consequence of):												
1	uted Id ransit	Examiner	if any, leading to immediate cause Enter Underlyin Cause (Disease or injury that initiated events c.													
0	icate be executed physician and is the burial-transit	edical Ex	resulting in death) Last Due to (or a	s a consequence of):												
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Med		2 Fetal death 3 at time of death 5	B	/		23d. Date of d Month	elivery Day Year							
ls, P.O.	uires that th n signed by uld be detac	by	Part II. Other significant conditions contributing to death	but not resulting in th	e underlying cause give	en in Part I.			to the cause of death? Probably 4 🛛 Unknown							
Division of Vital Records, P.O.	The law require: sate has been si, page 2 should l	Completed					24a. Was an autopsy performe	prior to death?	autopsy findings available o completion of cause of les 2 \(\sqrt{N}\)							
Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No Hospital: 1 ☐ Inpa	atient 2 🗆 ER/Outpa	Othe	r: 4 \(\sum \) Nursing H		ce 6 Other (Spe	ecify)							
ou of	nding Phyath. r; After thi	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of in (Month, L.)		/ work		28d. Describe how	injury occurred								
Division	al or Atte s after de il Directo ed in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of I building,	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	Bural Route Number,							
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best 2 Medical Examiner: On the basis of the control of the basis of	f examination and/or inv	estigation, in my opinio	 n. death occurred a 	at the time, date and	place, and due to the	e cause(s) and manner stated.							
			29b. Signature and title of certifier	^	29c. License	number 7-93 (a	29	d. Date signed (Mor	nth, Day, Year) - 2011							
	8 500		30. Name and address of person who completed cause of Hective D. Monuel V. 31. Date filed (Month, Day, Year) 32. Regis	f death (Item 23a) (Type	e, Print) Creene	St B	altimo	re M	21201.							
7	Sta Registr		31. Date filed (Month, Day, Year) 32. Regis	dar's Signature												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O1 Day 915 Physician/ Edwin Abell Dempsey 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hartor AIR Bel Air Health and Rehabilitation Center Bel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Min. Davs Hours Feb. 23.1934 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Wental Hygiene. Is marked other than "natural", or items 23a or 28a-f sho 10a. State Director 1 Yes X No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1317 Third Road 21220 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry Maintenance Man Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Dempsey Eva Abell permit. Page 1 and 2, should be Department of Health and Went Important: If item 27 is marke any injury or other traumatic e once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 804 Melody Court, Edgewood, Maryland 21040 James William Dempsev 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Ardent Cremation, Inc. 9-15-11 Hanover, Maryland 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. Signature of Funeral Service Licenses 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ gang rent disease or condition Medical resulting in death) Due to as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner signed by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of): Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Certificate: To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy within 24 hours after death.

To the Funeral Director: After this certificate has performe 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? 2 0 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Matural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Number Practicines To the cause of my knowledge death or more than the firm delicated and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Septemb1-10, 2011 D34652

Registrar

2835

SMITH AVE

BALTEMORE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HASWELL

31. Date filed (Month, Day, Year)

1 6 2011

M.D.

32. Registrar's Sanature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 = State Registra 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 14, 2011 Physician/ 6:55 Frances Whiten Dugan Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wilson Health Care Center Montgomery Gaithersburg 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1917 South Carolina (Month, Day, Year, September 6, 1 □ M 2 🎗 F 94 Director 251-14-9862 Usual Residence of Decedent Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland | Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20817 13 Savannah Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If Item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Education 4 Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olie Mullinex Thomas T. Whiten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 20817 13 Savannah Court, Bethesda, Frances Dugan Battey/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, 16, 2011 Bethesda, Maryland 4 Donation 5 Other (Specify) Inc. ROBERT A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Ave., Rockville, Maryland 20850 Signature of Funeral Service Licensee M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician the month disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine pue to lur as a consequence of If any, leading to immediate cause. Enter Underlying signed by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tes Completed been (24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed' 1 🗌 Yes 2 🗆 No 2 No After this certificate within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to media 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number 14. R. hert bis 04115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4. ROBERT BIRSCHBARLY UN

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) SEP 1 6 2011 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 29613 For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 12:00 PM Medical 4b. City, Town, or Location of Death **Examiner** altimore OY 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Hours **Director** ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 1 Ye 2 □ No Homos 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2121 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Completed by Baltimore, Maryland 21215-0036 1 □ Yes 2 No 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's 18. Mother's Name (First, Middle, Name (First, Middle, Last ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type Department of Health a Important: If item 27 is any injury or other trains 20b. Place of Disposition (Name of cemetery, crematory or other place . Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Dwings Forest 21. Sign turn of Inneral Service L 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ -WO disease or condition Medical resulting in death) Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 Z Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 2 No 2 N 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28c. Injury at work? 1
Yes Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 2 🗌 No Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

State Registrar 31. Date filed (Month, Da. Year) 32. Popular's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 15-20c, 22 per fh 9919 9-16-11 yt. 9 State of Maryland / Department of Health and Mental Hygiene For State Registrar 29614 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician/ 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltmore N/Ahock Irauma If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

Jan 4, 1931 9. Birthplace (State or Foreign Country) unk MD. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 🗆 M 2 🗶 F Months Director 80 220-32-5753 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State aţ Director Examiner must be notified 1 X Yes 2 No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code ъ 10e, Street and Number 21217 USA items 23a Funeral 3217 Baker St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Unit (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk-(Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) **FBI** Housekeeper unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk ဂ္ Richard Crutchfield Lottie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
43. Blackoak Ct., Reisterstown MMd-1 211 36 201 19a Informant's Name/Relationship (Type, Print) **Karen Dabrey (daughter)**Jniversity of MD Medical System 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 5 X Oth in-state 9-16-11 Baltimore, Md. 4 Donation on-site crematory 2140 V Ronal I ^{22.}Josephders of Brown 5. And PX PAT 655 W. Baltimore St; Baltimore, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate dause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner CHAMINER burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last PPROVED BY WEDICK Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be SERTIFICATION . Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months signed by the atte Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed Within 24 hours after death.

To the Funeral Director. After this certificate has been six

To the Funeral Director. Part to fineral director, page 2 should I 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examinera 1 Ves 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 횬 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: injury 5 Pending 1 Natural
2 Accident 800 (PM) 1 Tes Investigation WYSID 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Num) er or Rural Route Number, City or Town, State)

Output

12 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4800 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Da State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 296 | 5
State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	ato of Marylana	Cei	rtificate of D	Death	R	eg. No.					
P	hysicia	n/	1. Decedent's Name (First, Middle, Last)	Dagtag				2. Date of Deat Sept.		20 1°1 ′	3. Time of Death 11:56 А м			
	Medic	al .	Jacqulene Rosanna 4a. Facility Name (if not institution, give street	Doster and number)		4b. City. Town, or	Location of Death			nty of Death				
	Examin	er	3826 Leadenhall Str				cooklyn		Anne Arundel					
	uneral irector		5. Social Security Number 6. Sex 1 \square M	7. Age (In yrs. las	t <i>birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth June 11	[/] •1954	9, Birthp Coun	place (State or Foreign Maryland			
laryland	or other traumatic event, the Medical Examiner must be notified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Aru		Town or Lo	ocation Brook	klyn			1	0d. Inside City Limits 1 ☐ Yes 2 🗶 No			
with the N		Funeral Director	10e. Street and Number 3826 Leadenhall Str	eet	10f. Zip Code 21225						10g. Citizen of What Country? United States			
U36 's after death	ral", or items Examiner mu	þ	11. Marital Status 1 Never Married 2 Married	/as Decedent Ever in U.S. rmed Forces? ☐ Yes 2 ★No Yes, Give ear or Dates.			fas Decedent of Hispanic Origin? (Specify Yes or No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2X No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
1215-0030 hin 72 hours after	than "natu e Medical	Completed	15. Decedent's Educati (Specify only highest grade co Elementary/Seconday (0-12)		(Give	edent's Usual Occup kind of work done of DO NOT use retired) Pet St	during most of wor	king		of Business In	dustry			
e filed with	ed other t event, th	o l	17. Father's Name (First, Middle, Last) Charles Calvin Do	ster		Tet be		ne (First, Middle, M ene Erei	Maiden Surr		i i			
Baltimore, Maryland permit. Page 1 and 2 should be filed	tn and wer 27 is mark traumatio		19a. Informant's Name/Relationship (Type, P Erena Mattucci / Aur.	int)	19b. Mail	ing Address (Street)	and Number or Ru	ral Route Number,	City or Tow	n, State, Zip	Code)			
nore, I	Department of hear Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Tremation 3 Rem	20b. Pla	ace of Disp	osition (Name of ematory or other place	20)	Date	20c. Locat	ion - City or T				
Baltin Sermit. Pa	Deparme Importan any injun		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	lyson K Tay	lor 2	Name and Addre	ss of Facility $\mathbf{Cr}($	emation :	Socie	ty of l	Maryland			
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final	ons that caused the death.	Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death			
) N	sician /ledical aminer		Immediate Cause (Final disease or condition resulting in death) a. Due to (* as a consequence of):											
D		Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury	Due to (or as a conseque	ence of):									
3760 ficate be executed	physician and the burial-transit	al Exal												
8760 ificate b	physi s the t	Aedical	d											
Box 68 death certi	certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/N	in the past 12 months?	f yes, outcome of pregnan	death 3	☐ Ectopic pregnan☐ Other (specify)	cy		230	l. Date of deli Month	very Day Year			
S, P.O.	signed by 1 d be detach	þ	Part II. Other significant conditions contrib				iven in Part I.		tobacco use contribute to the cause of death? Yes 2 \(\sum \text{No} \) 3 \(\sum \text{Probably} \) 4 \(\sum \text{Unknown} \)					
Records, The law requires	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed	HYPEKTE	ENSTON				24a. Was autop perfo 1 ☐ Yes	osy rmed	prior to d	opsy findings available ompletion of cause of			
a F	rtificat ctor, pa	BeC	25. Was case referred to medical examiner?				Place of Death (Che							
Division of Vital	r death. sctor: After this ce by the funeral direc	은	1 ☐ Yes 2 ☑ No	1 L Inpatient 2 L I	ER/Outpati 28b. Time injury	of 28c. Inju	y at ry at rk?	Home 5 Resid			fy)			
VISIOF or Attend	arrer dearn Director: A in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At hor building, etc. (Specify)			Yes 2 No	28f. Location (S City or Tox	Street and N vn, State)	lumber or Rui	al Route Number,			
Hospital	24 hours: Euneral I leted filled	Medical (29a. Certifier 1 Certifying Physicial (Check 2 Medical Examiner: only one) 3 Certifying Nurse Pr	On the bacic of examination	and/or invi	estigation in my opin	ion, death occurred	l at the time, date a	and place, ar	na que to the c	ause(s) and mainer stated			
To the	within To the comp	2	29b. Signature and title of certifier	To the book of the		29c, Licens	se number		29d. Date s	signed (Month	, Day, Year)			
	1		1 00	MO			55506		09	1.15	12011			
,	3		30. Name and address of person who compore. Eren, 3721 Pote	eted cause of death (Item	23a) (Type 11time	, Print) Ore. Marv	land 2122	25						
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's fignat										
	Registr	ar	crp 1 6 2011 /	been p. 1	7									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Herbert J. Derwart 2011 7:53 A 09 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville 2 Park Drive 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 X M 2 □ F 1945 Maryland 65 **Director** 213-46-1509 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State at Director notified 1 ☐ Yes 2 💢 No Catonsville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō "natural", or items 23a or Funeral United States 21228 2 Park Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11 Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 Yes : WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Self-Employed Publisher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alma Loving Herbert J. Derwart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 9190 Twiford Court, Ellicott City, MD 21042 John Derwart, BROTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Maryland 09-16-2011 Lake View Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MacNabb Funeral Home P.A. Funeral Service Licensee gnature 301 Frederick Road, Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ 20 MINUTES INFARCTION ACUTE MYOGARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MAKIY YEARS ATHEROSCLEROS Sequentially list conditions Examiner rany, leading to infine date cause. Enter Underlying Cause (Disease or iinjury 10 YEARS TYPE I DIABETES the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 phy use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗖 No 3 🗋 Probably 4 🗎 Unknown fospital or Attending Physician; The law requires t Records, HIGH BLEED PRESSURE Completed 24b. Were autopsy findings available 24a. Was an autopsy HIBH CHOLESTEROL prior to completion of cause of performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after death

To the Funeral Director; / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29c. License number 29b. Signature and title of certifie 19030545 413 COMMON WEALTH AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

JEHN S. DAUTON

SEP 16

31. Date filed (Month, Day, Year)

ana yeard

M.D.

32 Registrar's Signature

11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 10 201 Edward Edmondson Jr. Michael Protentia Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Sinai Hospital <u>Baltimore</u> 8. Date of Birth 1. (Month, Day, Year) 1. 26 84 If Unde Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Months Hours MD 26 **Director** 215-27-630] 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No NA Baltimore MD 10g. Citizen of What Country? 10e. Street and Number Funeral 21215 U.S.A. 3118 Sequoia Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. ral", or iter I Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medico Elementary/Seconday (0-12) College (1-4 or 5+) Central Sterile Tech. Sinai Hospital 2th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Edmondson Jr. Sandra Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3118 Sequoia Ave, Baltimore, Md 21215 Ashley Edmondson-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Doyation 3 ☐ Other (Specify) On-Site 9/19/2011 Baltimore, Md 23a. Part 1. Et er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Due to (1 as a consequence of): Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Cana and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant a 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TRANSPlant 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? vAlve replacement Ricuspid page 2 s autopsy has performed' 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 R/Outpatient 3 DOA ဂ္ this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accider 5 Pending vithin 24 hours after co...

To the Funeral Director: After 1 Yes 2 🗌 No Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title

Registrar

DHMH 17 Rev 7/2009

State

Maryland

Baltimore,

P.O.

Records,

Division of Vital

Known as:

treat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Terence Engel Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Yea If Under 24 Hrs **Funeral** 1 **X** M 2 □ F Months Days Hours **Director** 219-46-2997 Jan 18, 1949 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗆 Yes 2 No Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4903 Rawcliffe Court 21043 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married <u>Ş</u> Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Consulting Accountant event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic eve မ J. Anthony Engel Dorothy Irene Travers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4903 Rawcliffe Ct. Ellicott City, MD 21043 Marian Engel/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 09/15/11 Woodbine, MD Signature of Funeral Service Licensee Name and Address of Facility tion Service P.O. Box 784 21029 Clarksville MD MO1251 Beverly L Heckrotte. PA Approximate Interval Between Onsettand Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-tran Due to (or as a consequence of resulting in death) Last the attending physician hed for use as the burial Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown 3 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tor: After this certificate has been signed the funeral director, page 2 should be del Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of performed 1 ☐ Yes 2 ☑ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician 24 hours after death. Funeral Director: After this certifi Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Anatural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho To the Fune completed fi (Check Certifying Nurse Practioner To the best of my Riconicage, death concurred at the time, date and plane, and due to the isale and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 0 108N and address of person who completed cause of death (Item 23a) (Type, Print) BAUTIMORE 2122

State Registrar CHARLES R GRAMOR

1 6 2011

31. Date filed (Month, Day, Year)

ino

1001 32. Registrar's Signature

Pive Heigh pe 5300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1:33 AM MARGARET NORA FRANCIS 201 SEPT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 T Hours Min 317 94 935 220-30-6812 76 MD Director Usual Residence of Deceden 10d. Inside City Limits 28a-f shor 10a. State 10b. County 10c. City. Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🗓 No MD HARFORD ABINGDON 10f. Zip Code 10g. Citizen of What Country? 9 10e, Street and Number 23a Funeral 21009 USA 3802 HEBRON TERRACE , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married WHITE 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 XWidowed 4 Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) RECEPTIONIST STATE OF MARYLAND Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ WALTER BURGESS NORA BARGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES LEHNER-SON 142 BRANCHWOOD CT ABINGDON, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State WOODLAWN CEMETERY 9/16/11 BALTIMORE, MD 4 Doration 5 Other (Specify) 22. Name and Address of Facility Signat SCHIMUNEK FUNERAL HOME OF BELAIR MACPHAIL BEL AIR, MD 21014 RD610 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ WOCavara disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Exami Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Month Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed has within 24 hours after deam.

To the Funeral Director: After this certificate hommeleted filled in by the funeral director, page 1 Yes 2 No 25. Was case referred 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; To the Hospital or Attending Natural 5 Pending Division 2 🔲 No 1 Yes Accident Investigation
Could not be □ Accider
 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 201

State Registrar 30. Name and address of perso

31. Date filed (Month,

0133Am

09/13/201

MADBADET

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Flanner 2011 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cood Samer tan Baltimore If Under 1 Year If Under 24 Hrs **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Months Days Min. Hours 76 July 20, 1935 Baltimore, MD 216-32-2121 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8005 Temple Avenue 21234 United States 12. Was Decedent Ever in U.S. Armed Forces? 14⊾ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Social Security (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administration Disability Claims Adjuster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Leo Flannery, Sr. Frances E. Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Heatth a Important: If item 27 is any injury or other tra Bonnie Flannery/Wife 8005 Temple Avenue, Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Glen Haven Memorial Park September 1 XBurial 2 Cremation 3 Removal from State Glen Burnie, MD 4 Donation 5 Other (Specify) 17, 2011 21. Signature of Funeral Service Licenses Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 al 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End. Staye Cardiomy path disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Records, Type IDM, HTN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 24 hours after death. Funeral Director: At 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Fractioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29c. License number 40059388 09-13-2011 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Rover Weisman Blut

Registrar DHMH 17 Rev 7/2009

State

Division of Vital

acke

32. Registrar's Signature

Ballimore MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29621 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Tao-Tsan Fan September 7, 2011 3:05 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 1 🖾 M 2 🗆 F Months Days 216-06-7196 91 April 26, 1920 China Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3734 Amsterdam Terrace 20866 Taiwan 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No 1 Yes 2 No Specify: Asian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Foreign Service Diplomat 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tienleen Fan Quanfen Chang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Fan/Son 9113 Vosger Court, Fairfax, Virginia 22031 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State September 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 18, 2011 Bethesda, Maryland Signature of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death disease or condition resulting in death) Aspiration Pneumonia weeks Due to (or as a consequence of) Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery in the past 12 months? Month Dav Year Yes 2 No 1 Yes 2 I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' 1 Yes 2 **X** 2 NO Yes 26. Place of Death (Check only one)

Physician/ Medical Examiner

and

physician

attending

the

ģ

this certificate

that the death certificate be Box 68760

or Attending Physician: The

P.O.

Records,

Division of Vital

Physician/

Medical

Director

Funeral

þ

Completed

Be

ဂ

Examiner

Funeral

Director

28a-f show

ō

"natural", or iterr edical Examiner

permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinone.

Baltimore, Maryland 21215-0036

notified

be ms 23a must be

-transit the use for detached signed by detail cate has l eral Director: After th filled in by the funeral within 24 hours a

To the Funeral C

Physician/Medical Examiner that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical Be examiner? 1 🗌 Yes 2 🔀 No Other: ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

188

Registrar

State

Barbara Ann Supanich, MD 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1 6 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Supanich RSU MD

Barbara

29c. License number

D0065485

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Physician/ PM RISTAL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITA1 Baltimore Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 0390811954 1 M 2 XF 57 Maryland 213-62-3724 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Randallstown Baltimore Co. MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3454 Carriage Hill Cir. Apt 101 21133 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) MTA Bus Operator МТА years Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ဂ္ Frances Richards John Jefferson 1 and 2 should to the alth and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, PrinDaughters | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21133 Keah & Kimberly Fryar 3454 Carriage Hill Cir. Apt 101, Randallstown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of Important: If it any injury or o oonce. 1

Burial 2

Cremation 3

Removal from State on-site Crematory $|\mathcal{O}|$ 4 ☐ Donation 5 ☐ Other (Specify) |Baltimore, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Facility
Joseph H. Brown Jr. Funeral Home PA INM 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examinet cause. Enter Underlying Cause (Disease or iinjury as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown cate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by with multi organ 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has t autopsy performed? death? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation the 1 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town. State: Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) September, 9, 2011 29b. Signature and title of certifier ween, D65843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Court Road, Randalls Town, MD 21133

DHMH 17 Rev 7/2009

Registrar

Abdallah

Barroux

5401

29623

			For State Registrar	State of Marylar		ertificate of L			eg. No.			
数	Physici		1. Decedent's Name (First, Middle, Las					Date of Deat Month	Day	Year	3. Time of Death	
	Physicia /Medic	al	ANNA		-BEI			SEPTEMA		2011 unty of Death	5:45PM	
	Examin	er	4a. Facility Name (If not institution, give	1		4b. City, Town, or	Location of Death			LTIMO	DE	
		- Of	MANOR CARE RI 5. Social Security Number 6. Se		last birthda		If Under 24 Hrs.	8. Date of Birth			place (State or Foreign	
	Funeral Director		219-18-0495	□м 2⊠г 87	Vre	Months Days	Hours Min.	Feb. 4,				
	/land		Usual Residence of Decedent 10a. State 10b. County	1	10d. Inside City Limits							
2	a-f sh ified	ctor	Maryland Harford	Abe	erdeen						1 XYes 2 No	
3	or 28a	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Country?			
	23a ust b		49 Norman Ave.			21001		- seife Von ar No	USA	Race - Americ	can Indian.	
	tems ter mi	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No	J.S. 13	If Yes, specify Cuban, Mexican, Puerto				Black, White,		
30	irs affe	by F	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 🏖 No	Specify:		Sp	ecity: W	hite	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. And other than "natural", or items 23a or 28a-f show do other than "materal Examiner must be notified at event, the Medical Examiner must be notified at	Completed	15. Decedent's Ec	lucation de completed)	16a. Dec	cedent's Usual Occup ve kind of work done	eation during most of wor	king	16b. Kind of		ndustry	
Z	ithin / ne. nan "i Med	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	- life		kind of work done during most of working O NOT use retired) Clerk		Diana			
7	ygier ygier ner th	ပ်	12			CTELK	18 Mother's Nam	ne (First, Middle,	Phar e (First, Middle, Maiden Sur			
ב פעני	2 should be filed vand Mental Hygie is marked other aumatic event, tt	Be	17. Father's Name (First, Middle, Last)	_				ne Wolfi				
2	12 should be in and Mental is marked o raumatic eve	유	Anthony Adam Hu		19b. Ma	ailing Address (Street					p Code)	
Ma	9 5 5 5		Stephen A. Hughes			1 Laurel E						
	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition	20b.		sposition (Name of rematory or other pla		Date		tion - City or T		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 ☑ Buylal 2 ☐ Creft ation 3 ☐ 4 ☐ Donation 5 ☐ D ther (Specif	Removal from State		Memorial	1	-2011	Bel A	Air, Ma	aryland	
= =	permit. I Departm Importar any inju		21. Signature of Funeral Service Lice	11		22. Name and Addre	ess of Facility MC	Comas Fi	mera.	L Home,	P.A.	
ñ	any and any					1317 Cokes				Maryla		
	1 % T 1 F	95	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the decone cause on each line.	ath. Do not	enter the mode of dyi	ng, such as cardiad	c or respiratory ar	rest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	DE.	MEN	TIA						
-	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):							
	Examine:	7.	Sequentially list conditions,	b. Due to (or as a conse	equence of):							
	ted nsit	i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		0							
,	execu n and ial-tra	Examiner	resulting in death) Last	C Due to (or as a conse	equence of):							
68760,	tificate be executed ig physician and as the burial-transit	edical		d								
89	rtifica ng ph as th	Medi	IF FEMALE:									
Вох	eath certif attending for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf preg 1☐Live birth 2☐Fe	etal death	3 □Ectopic pregnanc	су		23	 d. Date of deli Month 	Day Year	
0	ne dea the al	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	f death	5 ☐ Other (specify) _						
P.O.	The law requires that the death cert ite has been signed by the attendin page 2 should be detached for use		Part II. Other significant conditions	contributing to death but not re	esulting in th	e underlying cause gi	ven in Part I.	23e. Did t	obacco use	e contribute to	the cause of death?	
ds,	signe d be	d by						1 🗆	Yes 2	No 3□ Pr	obably 4 Honknown	
00	w req	Completed						24a. Was		24b. Were au	utopsy findings available completion of cause of	
æ	The law cate has page 2 s	E G						auto perfo 1∐ Yes	ormed?	death? 1 ☐ Yes		
ta		Be Co	25. Was case referred to medical				26. Place of De	ath (Check only				
<u> </u>		To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpa	atient 3 DOA Ot	ther: 4 Nursing	Home 5□Resi	idence 6	□Other (Spe	cify)	
Division or Vital Records,	ng Ph fter th neral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	iry Wo		28d. Describe	how injury	occurred		
<u>S</u>	Attending r death. ector: After by the funer	atic	2 ☐ Accident investigation]Yes 2∏No	29f Location	Street and	Number or R	ural Route Number,	
<u> </u>	or Att	Certification:	3 Suicide 6 Could not to determined		t nome, tarm ec <i>ify)</i>	, street, factory, office	3	City or To	wn, State)	Number of th	arar route remoon,	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	cal Ce	29a. Certifier 1 Certifying P	hysician: To the best of my luminer: On the basis of exam	knowledge, o	death occurred at the or investigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time	cause(s) a	and manner a place, and du	s stated. e to the cause(s)	
	To the H within 24 To the F complete	Medical	one)	and manner stated.			nse number				th, Day, Year)	
_	viti Cor	2	29b. Signature and title of certifier		Marketon Control		1722				R 13 2011	
	61			annulated agains of docts (II	M - D		1166		367	IC MISE	1013 2011	
	DV		30. Name and address of person who	SON MOD IN	286	REFENE T	REE ROA	0 #300 1	PILES	VILLE N	1021208	
	St	ate	31. Date filed (Month, Day, Year)	32. Strar's Si	gnature	7						
	Regist		SEP 16	2011 Surva	1.	garles						
-			UE!	7.	-	-						

		Please	e Type or Pri	nt in l	Black lı	ndelib	le Ink	. Ens	ure A	II Copie	s Are	Leg	ible.		
		For State	State of M	arylan					and M	1ental Hy	giene			0.06	0.1
_		Registrar 1. Decedent's Name (First, Middle, La	ast)		te of D	eath		2. Date of De	Reg. No	2 ()		296 3. Time of	24 Dooth		
Physicia Medic		Melville		emmi	.11					Month September 14, 20			Year 201	11 9:39	P ^M
Examin		4a. Facility Name (if not institution, give street and number) Gilchrist Hospice					4b. City, Town, or Location of Death Towson				4c. County of Dea Baltim			n	
Funeral Director		5. Social Security Number 216–16–5471 6. Sex 1 M 2 \square F 7. Age (In yrs. last 2 M 2 \square F 9				_ If Unde Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	(Month, Day, Year)				hplace (State o	r Foreign
th with the Maryland ms 23a or 28a-f show must be notified at	rector	10a. State 10b. County Maryland Balt:	ty, Town or Lo	or Location Towson								10d. Inside Cit	´		
with the is 23a or 2	Funeral Director	10e. Street and Number 1600 Ruxton Road	d Apt. A1			10f. Zip Code 21204					10g. Citizen of What Country? United States of America				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.			 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2XXNo Specify: 							k, White	rican Indian, e, etc. white	
hin 72 hou ne. than "nati ie Medica	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	kind of wo O NOT us	•	uring mos	t of worki	<i>n</i> g		ind of Bu						
be filed wit ental Hygie ked other ic event, <u>tr</u>	To Be C	12 4 Civil Engineer 17. Father's Name (First, Middle, Last) unk. 18. Mother's Name (First, Middle, Maunk.													
nd 2 should saith and M n 27 is mar er traumat		19a. Informant's Name/Relationship (19b. Mailii 3629	ng Addres Old	s (Street a	nd Numb ord	er or Rura Mill	Route Numbe	er, City or Ot • E	Town, S B Ba	tate, Zip Ltim	ore, MI	244
Page 1 anment of He tant: If iten		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	cify)	20b. F EV Cha	Place of Disponentery Pans Fu apel – I	sition (Na Inera Sel A	me of other place ir	e)	Sept	ëmber 2011				Town, State 1, Mary	land
permit Depart Impor any in		21. Signature of Fuveral Service Lice	Aseo		22 E	2. Name a	nd Address ul Alt 23	s of Facili emat 25 Yo	ives I rk Ro	Funeral a	and Cr	enat Mary	ion C land	enter, P 21093	.A.
Physician/		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused one cause on each line	the deat e. wblc	h. Do not ente	er the mod	de of dying	, such as	cardiac c	r respiratory ar	rest,			Approximate Interval Between Conset and E	e ween
Medical Examiner		Due to (or as a consequence of):													
e executed sian and urial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as												
cate be ex physician s the buria	ᇹ														
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	ast 12 months? 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) Month											,	∕ear
uires that the name of the signed by the detail	by	Part II. Other significant conditions	contributing to death b	out not res	sulting in the u	ınderlying	cause give	en in Part	l.					the cause of de	
sician: The law req certificate has bee lirector, page 2 sho	Completed									24a. Was auto perfo	psy ormed?		orior to d death?	topsy findings a	
ician: Dertifica	Be	25. Was case referred to medical examiner?	Hospital:				26. Pla		th (Check	only one)		9			
nding Physath. r: After this se funeral di	icate: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of inju (Month, Da	ry	28b. Time of injury		28c. Injury work?	4 <u> </u>		me 5 Resi 28d. Describe I				ify) Hospi	<u>ce</u>
tal or Atte	al Certificate:	3 Suicide 6 Could not determined	be 28e. Place of Inju							28f. Location (City or Tox			er or Rui	ral Route Numb	er,
the Hospi hin 24 hou the Funer upletely fil.	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best of niner: On the basis of e rse Practitioner: To th	xamination	n and/or inves	tigation, in	my opinior	n, death o	ccurred at	the time, date a	and place	, and due	e to the o	cause(s) and ma	nner stated.
To to con		29b. Signature and title of certifier	071	4			c. License		_		29d. Da	te signed	(Month	, Day, Year)	
X	ŀ	30. Name and address of person who		eath (Item	n 23a) (Type, F		D007	063	5		7/1	571			
, v		Coura Pafel 31. Date filed (Month, Day, Year)	6701 10		iles s	में 5	u'te	416	5	Balh	mor	PM	10	21204	f
Stat Registra	~	SEP 1 6 2011	32. Registra	ar's Signat	ture										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1921 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Grove Monto Ad Ock VII vend Hospita 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ (Month, Day, Year 02/07/ Months Hours Country) England **Director** n/a 1950 Usual Residence of Decedent 28a-f shov 10b. County Oc. City, Town or Location
Gaithersburg 10d. Inside City Limits 10a State 72 hours after death with the Maryland Medical Examiner must be notified at **Funeral Director** Montgomery MD 1 🗌 Yes 2X No 10g. Citizen of What Country? Ь 10e. Street and Numbe 10f. Zip Code 20877 49 West Diamond Ave Apt304 'natural", or items 23a England 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hughes, John and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Glass Stain Glass 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Owen Hughes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai once. 49 West Diamond Ave Apt302 Gaithersburg MD <u>Laura Malin Auth Agent</u> 20b. Place of Disposition (Name of cemetery, crematory or other partic Crem 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 9/10/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licensee ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Myocard minutes Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or linjury Examine Due to (or as a consequence of): use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Dav Pregnant at time of death 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 🔲 No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Mapper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number rson who completed cause of death (Item 23a) (Type, Print) Rockville, MD MAT Dr 9901 medical 32. Registrar's Signature State Registrar

amend 5,19b, perfh, g920 10-21-11 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Peath County of Death War 6. Sex If Unde **Funeral** 8. Date of Birth 1 🗆 M 2 🗹 Months Hours Min. Director MATTON Jsual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anoie. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 🗌 No 101. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral ST ree. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use reti<u>red)</u> College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna 2 19a. Informant's Name/Relationship (Type, Arint) 19b. Mailing Address (Street and Number or Rural Route Number Of Yor Town, State Zip Code) Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Departion 5 Other (Specify) Sig cur Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading the innectal cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in dooth). Examiner e the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 \square Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗀 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) D0064024 Tokama MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THNNA LACHTCHININA 5 V M.D.

State

Registrar

31. Date filed (Month, Day, Year)

16

32. Registrar's Signature

Washington Adventist Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011

		1- For State Registrar	Certificate	of Death		2 U I .	2902						
Physici Medical Exam		Decedent's Name (First, Middle, Last) Terri Ann Hannibal	2. Date of Deat	h	3. Time of Death 0105 hrs								
THOUGH EXAMIN	mei	Terri Ann Hannibal Month Day Year September 10, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death											
		4724A Old Mill Bottom Road (in vehicle) Mount Airy Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace											
Funeral Director	Director 214-88-6307 1 M 2X F 44 Yrs. Months Days Hours Min. 09/03/1967												
faryland 28a-f show any lat once,	ctor	Usual Residence of Decedent 10a. State 10b. County MD Frederick 10e. Street and Number	10c. City, Town or Loc Brunsw			og. Citizen of What Coun	10d. Inside City Limits 1 Yes 2 No						
the Ma 'a or 28	Director	214 9th Ave		21716		US	•						
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinor must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 Married Armed For 1 Yes 3 Widowed 4 Divorced If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade	ces? If 2 No	Vas Decedent of Hispanic Oriç Yes, specify Cuban, Mexican Yes 2 \(\bigcit{N} \) No specify: ent's Usual Occupation (Give)	Puerto Rican, etc.)	White, etc. Specify: Bla	ck						
hin 72 hour e. than "natt	Completed	Elementary/Secondary (0-12) College (1-2 2 yrs	during	most of working life. DO NOT		16b. Kind of Business/Ir Beauty	idustry						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)			s Name (First, Middle, N								
121 Id be fi fental narked event,	o Be	Ernest Hannibal Viola Eberhart											
MD 2 td 2 shou ulth and N m 27 is n	٩	Viola Hannibal Moth		West Belve		•							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fror 4 Donation 5 Other Specify:		osition (Name of cemetery, other place) CCEM	Date 9/15/11	20c. Location - City or Glen Bur	·						
Balti permit. Departr Imports injury o		21. Signature of Furieral Service Licensee	22.	Name and Address of Facility ChomasAllenP	Simplicit	y Crem &	Fun Serv						
Physician \/Medical		23a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line.					Approximate Interval Between Onset and						
Éxaminer		Immediate Cause (Final disease or condition resulting in death) a. Cocaine Due to (or as a company)	morphine and onsequence of):	methadone In	toxictaion		Death						
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ernor Underlying Cause (Disease or injury that initiated	onsequence of):										
ited d ansit		events resulting in death) Last Due to (or as a c	onsequence of):										
60, ate be execu hysician an e burial - tr	Medical		3a,27,28a-f,	per me,g919 9-	-20-11 sm								
x 687 h certific ending p use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	at at time of death	etal death 3 Ectopic	pregnancy	23d. Date of delivery Month D	ay Year						
C BO t the deatl by the att ached for	Phys	1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to c		underlying cause given in Pa	tt I 23e Did to	bacco use contribute to t	he cause of death?						
B, P.O.	Ď	- Continued of the cont	- Total of the control of the contro	didenying cause given in ra		2 No 3 Proba							
	Completed				24a. Was a autops perfort 1 ✓ Yes 2	sy prior to co med? death?	opsy findings available ompletion of cause of						
ital Relician: The secrificate rector, page	Be	25. Was case referred to medical examiner?	patient 2 ER/Outpatier	26.Place of Death (Residence 6 🗸 Other	Cons						
Division of Vital Records, To the Hospital or Attendiog Physician: The law requir within 24 hours after death. To the Fuoeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should to	itlon: To	27. Manner of Death 1 Natural - (Month, D	Injury 28b. Time of	Injury 28c. Injury at Work	? 28d. Describe h	ow injury occurred	Scene						
Divisited or Attours after done after done filled in by	Certification:		of Injury - At home, farm, str found in	eet, factory, office building, etc	or Town, St	treet and Number or Rur ate4724A 01d 1 Airy,MD.	al Route Number, City 1111 Bottom						
Division To the Hospital or Attenwithin 24 hours after death To the Fuocral Director:	Medical C	29a. Certifier 1 Certifying Physician: To the best of cone 2 Medical Examiner: On the basis of and manner sta	examination and/or investig		ce, and due to the cause	e(s) and manner as state							
	Ž	29b. Signature and title of certifier)0	29c. License number O.C.M.E.		29d. Date signed (Mon September 10, 20							
0	}	30. Name and address of person who completed cause Patricia Aronica-Pollak MD. Assistar		900 W. Baltimore Str	eet Baltimore MC								
St			strar's Signature	******									
Regist DHMH 17 Rev 1/2	_	SEP 1 5 2011 A.	we 3. 60	aled									
OCME 2006	001	OCME	ORIGINA	4L									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09 Month Physician/ 08^{ay} 2019 5:15A Vernon Hutchins Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore 1728 N. Payson St. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours **X**□ M 2 □ F 0972677931 Maryland 79 214-26-2023 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State notified at Director ¹X☐ Yes 2 ☐ No N/A Baltimore 28a-f MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Page 1 and 2 should be filed within 72 hours after death with the irnent of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or iury or other traumatic event, the Medical Examiner must be 1 Funeral U.S.A. 21217 1728 N. Payson St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. ò 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Baltimore City (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Teacher years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Emma Shaeffner Vernon Hutchins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4817 W. Forest Park Ave., Baltimore, MD21207 Department of Health Important: If item 27 any injury or other tronce. Argin Hutchins(uncle) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 remation 3 Removal from State on-site Crematory 09/19/11 Baltimore, MD 4 Donation 5 Other (Specify) එර්ප්පුර්^{Ad}ffs of brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licensee hich N. 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Onknown 1 Yes icate has been s r, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical examiner? 2 No Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director, After this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier ٥ D0069314 09 8873 Walthom Wood Rowerle MD 21234 who completed cause of death (Item 23a) (Type, Print) . Name and address of person nati (No 31. Date filed (Month, Day Year) 32 State

DHMH 17 Rev 7/2009

Registrar

Please Type of Printin Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 29629 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last)
Carmen Beatriz Calcano de Iribarren 2. Date of Death Day Physician/ Month Carmen Iribarren 2011 10:20 PM September Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4620 N. Park Avenue, #604E Chevy Chase Montgomery 8. Date of Birth (Month, Day, Ye December 3 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 80 Venezuela Director 579-92-5846 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director be notified 1 🗌 Yes 2 🔀 No Chevy Chase Maryland Montgomery 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? by Funeral Venezuela "natural", or items 23a idical Examiner must l 4620 N. Park Avenue, #604E 20815 permit. Page 1 and 2 should be filed wirthin 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 🕱 Yes 2 □ No Specify: Venezuelan 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Octavio Calcano Adela Spinetti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5301 Westbard Circle, #202, Bethesda, Maryland 20816 Manuel L. Iribarren/Son 20b. Place of Disposition (Name of cemptery, crematory or other place)
Montgomery
Crematorium, Inc. September 17, 2011 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase A. Tuc. 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 dop M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Hepatic Coma Medical Due to (or as a consequence of): Examiner 1 month Hepatocellular Cancer Sequentially list conditions. Examine if any, leading to immediate cause. Enter Unuerlying Cause or iinjury Due to (or as a consequence of): 10 years Cirrhosis the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 20 years Hepatitis C 一代は十つから Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown should 24b. Were autopsy findings available 24a, Was an cate has I prior to completion of cause of death?

1 Yes 2 No autopsy performed? certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation after deatl Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours Funeral Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Carlifying Nurse Fractioner to the best of my his wile consistent of the date of the cause of th (Check or IV or s 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a title of certifier September 13, 2011 D0022154 30 30. Name and address of perso wh completed cause of death (Item 23a) (Type, Print) 2021 K Street, NW Suite T-110, Washington, D.C. 20006 MD Louis Korman, Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2011 SFP 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:00 P_{M} Physician/ September 11, 2011 Maxine Jenks Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Patuxent River Health & Rehab Laurel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days 577-56-5342 1 M 2XX **Director** 67 February 15, 1944 Wash. D.C. 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits notified at Director Maryland Howard 1 Yes 2X No Columbia 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 7070 Cradlerock Way Apt. 420 21045 United States of America "natural", or iterredical Examiner 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 TNo Specify. Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Kind of Business/Industry
COM Fabrications (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Copy Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ Levine Bernard Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) strait. Page 1 and 2 straitment of Health a prortant: If item 27 is Kim McNeills 8527 Guilford Rd., Columbia, Maryland (Daughter) Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date pernit. Page 1
Derartment of Important: If it any injury or o once. Atlantic Crematory 09/13/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signatura of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home@ Meadowridge Memorial Park Inc., Elkridge, MD 23a. Part 1 🔚 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ARTERY DISEASE disease or condition resulting in death) COYONOYY Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be execut-Cause (Disease or injury that initiated events resulting in death) Last physician are the burial-t Due to (or as a consequence of) Physician/Medical Box 68760 for use as IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Day 1 Yes 2 D Month Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, Cerebrovasalor discoss 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' Hospital or Attending Physician: The Yes 2 X No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 1 Yes 2 🔀 No ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending Accident Investigation 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse, Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated dolar 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 1315 2011 53411 Sept 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gallant Fire 210 F Bouse 20715 31. Date filed (Month, Day, Year)
SEP 1 6 2011 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29631 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 4:19 PM Physician/ elia Septembe 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Balkmore Baltimore Jahan 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Hours 220-78-397 Director 1 🗆 M 2 💋 F Irinidad show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director Yes 2 🗆 No Baltimore 28a-f altimore 10g. Citizen of What Country? ö 10e. Street and Number or than "natural", or items 23a or the Medical Examiner must be Funeral SA 2120 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married Z1215-0036

Zamer, Page 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked any injury or attended. þ 1 ☐ Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life_DO NOT use retired) 16b. Kind of Business/Industry 8 Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last, prom ည Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 20b. Place of Disposition (Name of cemetery, crematory or other place, Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HIMEL 4 Donation 5 Other (Specify) 22. Name and Address of Facility Horse Howell Balto MU Height 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Basal ganglia nenomhage disease or condition Medical resulting in death) Due to (or as a con-equence Examiner eans Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine or as a consequence of) use as the burial-transit and Due to (or as a consequence of): attending physician for use as the buria To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the at be detached for 1 Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an horano has page 2 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Medical Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes I ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 10 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie RES-OUD September, 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Of Balhmore Sinou 31. Date filed (Month) State SFP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Year **Medical Examiner** Lori A. Leeper 1610 hrs September 9, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8708 Satyr Hill Road Parkville **Baltimore County** 5. Social Security Number 6. Sex 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. Director Months Days Min. Hours 212-76-8937 50 01/24/1961 1 M 2 F Country) MD Yrs Usual Residence of Decedent 9 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore or 28a-f show Parkville 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
satt: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8708 Satyr Hill Road 21234 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 2 X No 1 Yes 4 X Divorced White 3 Widowed If Yes. Give Year 1 Yes 2 X No specify: Specify. <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry event, the Medical Exduring most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 1yr Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jimmy Kegley Carol Whalen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jimmy E. Arbogast 5604 Essex St. Churchton MD 20733 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Atlantic Crem 9/12/11 Glen Burnie MD portant: tment 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease Hypertensive Atherosclerotic Cardiovascular Disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical tending physician use as the burial **X** UNPENDED 23a,27 per me g920 10-5-11 vt AMENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 Unknown Completed icate has been s page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed' death? ✓ Yes 2 No 1 Yes To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifit completely filled in by the funeral director, ! 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Division Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 10, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, State 1 6 2011

DHMH 17 Rev 1/2001

Registrar

OGME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #20b Per FH G920 10/03/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANISON Month Day 3 Year 2011 ZABRIA 09 2130 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HARBOR HOSPITAL BALTIMORE CITY N/A If Under 1 Year If Under 24 Hrs. 8, Date of Birth 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Hours Min 0471972008 Maryland 217-81-0208 3 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD N/A Baltimore 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? with 1 Funeral items 23a 1210 Cherryhill Rd. Apt F 21225 U.S.A. hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 ☐ Married ō þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: Black 'natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) N / A College (1-4 or 5+) N/A N/A Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Dionte Lawson Sheikia Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 Sheikia Coleman(mother) 1210 Cherryhill Rd. Apt F, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9/23/2011 cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion Cem. 109/16/11 Mt. Baltimore, MD 21. Signature of Funeral Service Licensee Joseph Address of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, any in PA MD LAMS 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASCVD Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Por in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant Pregnant at time of death Yes the detached 9 Unknown Arter this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DANDY-WALKER SYNDROME 1 Yes 2 No 3 Probably 4 Unknown TRACHEU- ESOPHAGEAL FISTULA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D0070999

Registrar

DHMH 17 Rev 7/2009

State

3001 SOUTH HANDVER STREET BACTIMOREMA 21725

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARLISLE

EMILY STREYER

SEP 16

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MO9/10/2011 Physician/ John Thomas Lebatell 5:52p ^M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Center 9. Birthplace (State or Foreign Social Security Numbe . Age (In vrs. last birthday Year If Under 24 Hrs. 8 Date of Birth **Funeral** Country) 212-50-5409 Hours (Month, Day, Year) 01/05/1947 64 MD 1 🛛 M 2 🗆 F Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a State aţ with the Maryland Director 1 XYes 2 □ No notified Baltimore MD 10f. Zip Code 10g. Citizen of What Country? ō 10e Street and Number Examiner must be USA 23a 5107 Underwood RD 21212 Funeral items death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Completed 3 Widowed 4X Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry e 1 and 2 should be filed within 72 Person 2 Health and Mental Hygiene.
If item 27 is marked other than "nor other traumatic event, the Median Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Worker 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John James Lebatell Rita McGowan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5107 Underwood RD Baltimore MD 21212 John J. Lebatell Father 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place)
Atlantic Crem 20c. Location - City or Town, State 9/14/11 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature of run ral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ monthe disease or condition Medical resulting in death) for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami ician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No after death.

Director: After this certificate has death? 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: hospile 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Certificate: injury work? 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Division of Vital Records,

To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. It

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles ST 31. Date filed (Mo

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar 29635 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 02 30 A M 2. Date of Death Physician/ Month September Evelyn Scott Martin 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death Howard Brighton Gardens of Columbia Columbia Social Security Numbe 9. Birthplace (State or Foreign Country) VA 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2**X** F Min. Hours Director Yrs 216-34-4239 Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 1 Yes 2 No Columbia MD Howard 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be LISA 21045 7110 Ministral Way apt. 214 items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African-American If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 □ Divorced "natural" Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) er than Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Jail event, th Counselor Be 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H
27 is marked of
r traumatic ever ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5382 Smooth Meadow Way, Apt. 24, Columbia, MD 21044 Department of Health Important: If item 27 any injury or other to once. Nellie Gamer/ Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Solution 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-16-2011 Baltimore, MD Cedar Hill Cemetery Donation 5 Other (Specify) Whie Fireral Home P.A. of Balto. Co. 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Priysician/ reast Cancer years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes 2 X No 1 Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted. examiner? Other: 1 Yes 2 X No ပ္ 4 ☐ Nursing Home 5 ☐ Residence 6 🗴 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending work 1 Tes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number m.D. D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li 8600 Snowden River pkwy #301, Columbia, MD21045

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MART Month F.DA 3:15 PM SEPTEMBER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOSPITA1 TOWN NORTH WEST RANDALLS Baltimore 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 216-30-9219 **Director** 1 □ M 2 🔀 F 77 12 07 33 MD Usual Residence of Deceden 28a-f shov 10a. State filed within 72 hours after death with the Maryland notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 1014 Witherspoon Road 21212 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: Black "natural" Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. US Army Corps ementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the 12th grade lyr ead Voucher Examiner Engineer Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur Johnson Elizabeth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jayetta Moore-Daughter 1014 Witherspoon Road, Baltimore, Md 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9 Department of Important: If any injury or once, Arbutus 9/23/2011 Arbutus, Md Memorial Si atura of Funeral Service Lice 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final NEUMONIA Ph. sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Directo for as a consequence of the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑No Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Yes 2 X No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital. Other: 1 ☐ Yes 2 No မ 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54352 SEATEMBER 11:05 MIRCEA TODOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar NORTHWEST

31. Date filed (Month, Day, Year)

HOSPITAL

SHO! OLD COURT ROAD RANDALLSTOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Year Month 50 Malinow SKI Physician Hagela 50 Dtember 14, 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 -18 -19 18 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Maryland 1 □ M 2 □ XF 93 **Director** 220-09-8957 Usual Residence of Decedent permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Funeral Director Nottingham Md. Balto. 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21236 e Apt J

12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes, 2 W No
If Yes, Give
Year or Dates: USA 3 Dunsinane Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: ģ 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Home 6th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Kamuda ည Aloizy Siewierski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nottingham, Md. 21236 DTR. 3 Dunsinane Dr. Apt.J Adele A. Hennessey 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9-17-2011 Dundalk, Md. 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee Bucin a 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Stroke Immediate Cause (Final Physician disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): nding physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Tectopic pregnancy 1 Live birth 2 Fetal dead Year Month Day ρ 5 Other (specify) 2 NO 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 2 No 3 Probably 4 Chknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Tes 2 **X**No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Anpatient 3 □ DOA 2 ER/Outpatient 1 Yes 2 No ၉ After this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury 27. Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by the Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 🗌 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) within 2 To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 14,2011 CMANA BALFOUTH, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 MONA BAITOUTH, MO parke 31. Date filed (Month, Day, Year) 3. Registrar's Signature

DHMH 17 Rev 1/2001 11595

State

Registrar

SEP 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 29c, per phy, 2919 9-16-11 sm
State of Maryand Department of Health and Mental Hygiene

		_1	For State Registrar	Otate of Maryland		tificate of D			eg. No. 20	- 29638 1	
	Physicia Medic	ın/	Decedent's Name (First, Middle, Las John Joseph	•				2. Date of Death Month Septembe	er 13, 201	1 12:16 P. M	
	Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dear	th	
	,		Dove House	15.00	to both stood	If Under 1 Year	stminster If Under 24 Hrs.	8. Date of Birth	Carroll	thplace (State or Foreign	
	Funeral Director		117-20-1887	ex		Months Days	Hours Min.	(Month, Day,	Year) 1928 New	nuntry) 7 York	
	nd how at	I. I	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits	
	taryla 3a-f s tiffied	Director	Maryland Carroll		W	estminster			1 ☐ Yes 2 🛭 No		
	with the N 23a or 2 Ist be no	Funeral Di	10e. Street and Number 591 Scott Drive	•		10f. Zip Code 21	1157		Og. Citizen of What Country? United States of America		
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland to 6 Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	۾	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏅 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates.	1 -	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🔏 No	ispanic Origin? (Spec in, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W		
2-0	2 hour	Completed	15. Decedent's E (Specify only highest gra		(Give F	lent's Usual Occup	ation during most of workir	ng	16b. Kind of Business	Industry	
121	thin 72 ne. than the Me	顺	Elementary/Seconday (0-12)	College (1-4 or 5+)		ONOT use retired) self empl	oved		Collison 1	Repair	
Maryland 21215-0036	be filed wit ental Hygie 'ked other ic event, th	a	17. Father's Name (First, Middle, Last)	- Millon		CII GREE	18. Mother's Name	(First, Middle, M			
ylaı	should be file and Mental F 7 is marked o raumatic eve	욘	John Frankli								
Mar	d 2 shou alth and 1 27 is r er trau m		19a. Informant's Name/Relationship (T Deborah Lynn Mill	ype, Print) Ler/dau.—inlaw	19b. Mailir 591	Scott Dr	and Number or Rural ive Westm	City or Town, State, Z Maryland	21157		
Baltimore,	Page 1 and 2 s nent of Health s ant: If item 27 i ury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Removal from State 20b. Pla	nce of Dispo metery, crem ns Fur apel –	sition (Name of natory or other place neral Bel Air	Septe 16,	mber	20c. Location - City o	r Town, State	
Balti	permit. Page Department of Important: If any injury or once.		21. Signatur Fundral Service Licens	Tee t		Name and Addre	Statilities Fi	neral and Timoniu	Cremation C m, Maryland	enter, P.A. 21093	
			est,	Approximate Interval Between							
	Ph, sician/		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ease	Onset and Death						
-	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	1	Rena				
			Sequentially list conditions, if any, leading to in module cause. Enter Underlying	b. Justic (or as a conseque	nes offi	2000					
	d ansit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events	C							
	ficate be executed g physician and as the burial-transi	EX	resulting in death) Last	Due to (or as a conseque	ence of):						
8760	ate be physic the bu	Medical		d							
Box 6	death certi re attendin ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 Live Birth 2 Fetal 4 Pregnant at time of de	death 3 L	☐ Ectopic pregnan ☐ Other (specify)	су		23d. Date of d Month	elivery Day Year	
s, P.O.	res that the signed by the	þ	Part II. Other significant conditions of	contributing to death but not resu	Iting in the u	underlying cause gi	iven in Part I.		bacco use contribute	to the cause of death? Probably 4 Unknown	
of Vital Records,	has has	Completed						24a. Was a autop:	sy prior to med?/ death?	autopsy findings available completion of cause of	
al B	ician: The certificate ector, pag	BeC	25. Was case referred to medical			26. P	lace of Death (Check		2 (110)	_	
Vit	S	일	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Inpatient 2 E			4 Nursing Ho		ence 6 Other (Spe	ecify) 137 W	
n of	ne fer	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Year)	28b. Time o Injury	wor		28d. Describe ho	ow injury occurred	to up	
Division	l or Atter after des Director d in by th	Certificate	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		ne, farm, str	reet, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,	
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completed filled in by the fu	Medical	(Chook 7 Medical Evan	vsician: To the best of my knowled niner: On the basis of examination rse Practioner: To the best of my	and/or inves	stigation, in my opin	ion, death occurred at	t the time, date ar	nd place, and due to th	e cause(s) and manner stated.	
	To the within To the comp	2	29b. Signature and title of certifier	1 A Ax		00 1:	71746		29d. Date signed (Mor	,	
- A	10		30. Name and address of person who	completed cause of death (Item		Print)		1-1	1 20 1		
O.	Sta	ate_	Dana L 31. Date filed (Month, Day, Year)	2) Mento 59	55 S	· Cent	er St. V	vestmi	nster Mi	0 21157	
	Regist		SEP 1 6 2011	32. Registrar's Signatu							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MINI DAIN SEPTEMBER Year 2011 MILLER 12 9:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CENTER BALTIMORE WASHINGTON MEDICAL GLEN ANNE ARUNDEL BURHIE Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) PA. **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 🗆 M 2 💢 F Months Days (Month, Day, Year) 01/29/1928 189 22 5595 **Director** 83 Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland Anne Arundel Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 5522 Moore Street 21225 U.S. and 2 should be filed within 72 hours after death . Health and Mental Hygiene. tem 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) MILLER VIRGINIA $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12\text{t}h \end{array}$ College (1-4 or 5+) White Coffee Pot Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Giovanni Brunetti other traumatic Amelia Barretta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belinda Sunstrom / Daughter 8104 Foxhunt Circle Glen Burnie, Maryland 21061 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Glen Haven Mem. Park 09/16/2011 4 Donation 5 Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final SERSIS Onset and Death Physician/ ase or condition 2490 Medical resulting in death) Due to (or as a consequence of) Examiner PPAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or imjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ul or Attending Physicians: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 \(\subseteq \) Yes 2 \(\subseteq \) No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 🎮 No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Nation 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

Registrar DHMH 17 Rev 7/2009

State

To the Hospital within 24 hours a To the Funeral D

Medical

1 X Natural

☐ Accider☐ Suicide Accident

4 Homicide

only one)

31. Date filed (Month, Day, Year)

SEP 1 6 2011

29a. Certifier

5 Pending

Investigation

determined

Will Draw you Grand poer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

injury

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

GUICLEAMO JOSÉ GIANGRECO BOI HOSPITAL DAIVE, GLEN BURNIE, MD ZOIGI

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1553000

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2664EHBEK 12,20**11**

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

11-06612 Tracey Musgrove Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 1 1 29640
State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Reg. No.										
Physicia Medical Examir	n/	Decedent's Name (First, Middle, Last)	Tracy Ly	n Musg				2. Date of Deat Month Septembe	Day Year r 1, 2011	3. Time of Death 0000 hrs
)		4a. Facility Name (if not institution, give Harbor Hospital	street and number)			Town, or Lo	ocation of Deat			/A
Funeral Director		5. Social Security Number 6. Sec. 216 02 7533		(In yrs. last bi	rthday) If Un Mont	der 1 Year ths Days	If Under 24Hr Hours Mi	_	th(MM/DD/YYYY) S 2/1968	D. Birthplace (State or oreign Country) Maryland
21215-0036 should be filed within 72 hours after death with in and Mental Hygiene. is marked other than "matural", or items 23, artic event, the Medical Examiner must be no	Usual Residence of Decedent 10a. State							Specify Yes or No o Rican, etc.) work done tired) we (First, Middle, No et an Evonr	White, e Specify: 16b. Kind of Busin (unknown Maiden Surname) 1e 0 Neale nber, City or Town,	American Indian, Black, etc. White ness/Industry wn) e State, Zip Code) SSee 38572
Balti permit. Departn Impurti		Burial 2 X Cremation 3 Donation 5 Other Specify: Sign rure of Funeral Service Linens A Donation 1 Service Linens A Donation 2 Service Linens A Donation 3 Other Specify: A Donation 5 Other Specify:	Piedas	Bayv:	iew Crema 22. Name an	e) atory nd Address o Ritchi	09 of Facility Gie High	once Fun way Bal	eral Serv timore, N	ore, Maryland vice, P.A. Maryland 21225
Physician Medical Examiner	Examiner	failure. List only one cause on earlinmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, for any localing transmission of the cause. Enter Underlying Cause (Disease or injury that initiated cause or cause on the cause of th		Morphinguence of):						Between Onset and Death
Box 68760, te death certificate be executed the attending physician and red for use as the bunial - transit	Physician/Medical E	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant at t 9 Unknown	e of pregnand	y 2 Fetal deat 5 Other (Sp	h 3	Ectopic pregi	nancy	23d. Date of de Month	
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed by	Part II. Other significant conditions 25. Was case referred to medical	contributing to death	but not result	ing in the underlyii		of Death (Chec	1 Yes	s 2 No 3 an 24b. We prive dear dear	Probably 4 Unknown ere autopsy findings available or to completion of cause of ath? Yes 2 No
Sion of Vita Attending Physician death ctor: After this cer y the funeral direct	ation: To Be		ospital: 1 Inpatier 28a. Date of Injur (Month, Day, Ye on	28i 28i 11 u	Outpatient 3 D. Time of Injury	28c. Injury	at Work?	unknown	how injury occurred	
Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Certification:	3 Suicide 6 X Could not determined	28e. Place of Inj	reside						or Rural Route Number City Hospital 3001 altimore, Md.
O To the Ho within 24 To the Fu completel	Medical	one) 2 Medicai Examiner	an: To the best of my On the basis of exan and manner stated.	nination and/c	r investigation, in	my opinion,	death occurred	at the time, date	and place, and due	e to the cause(s)
Opp.	Z	29b. Signature and title of certifier	King I	L, in	·D.	O.C.N	0	CME	September 2	
4		30. Name and address of person who a Theodore M. King, Jr., MD	. Assistant M	edical Exa	miner 900 V	V. Baltim	ore Street,	Baltimore, M	D 21223	
St Regis		SEP 1 6 201	32. Registrar	s Signature	A. Carrier and Car					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 2 per doc g919 9-16-11 vt

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2011 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Se D Physician/ 8474 M 1922R 07 Medical 4c. County of Death
BELT: More 4a. Facility Name (if not institution give street and number Examiner Kellston Rance 25 DITE Cenz If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 Year 7. Age (In vrs. last birthday) **Funeral** ех **Х**ім 2 □ ғ 1271671924 Months Days MD **Director** 216-20-2017 86 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified 1 🗌 Yes 2 😾 No OWINGS MILLS BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4650 ALCOTT WAY, UNIT 303 21117 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. Specify Completed 3 Divorced WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PHARMACIST PHARMACY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SCHEIR JOSEPH MAZER ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4650 ALCOTT WAY, UNIT 303, OWINGS MILLS, MD 21117 JOYCE MAZER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 09/15/2011 BETH TFILOH CEMETERY BALTIMORE, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. once, COM 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rd:onyo Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any leading to immediate cause. Enter Underlying Examine -transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) the burial attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day 5 Other (specify) Month Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 24 hours after death. E Funeral Director; After this certificate has Yes 2 No 1 Yes 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 1 Yes ည Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one) 29b. Signature and title 29d. Date signed (Month. Dav. Year) 1053850 enber 13,20, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwest Has Steven J. Siguartzins

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

				Plea					ndelible In			•		_	
		-	For State		S	tate of	Marylan		artment of I rtificate of L		and M	lental Hy	- /	' [] [] [29642
		-	Registrar 1. Decedent's Nan	ne (First, Middl	e, Last)				tincate of L	Jeaun		2. Date of De	Reg. No.		3. Time of Death
ш	Physicia Medic		RUTH			1	MARKOVI	TZ				Septem	Day	29 11	2:10 A M
Maria Maria	Examin		4a. Facility Name (_	LTIMOR	LE	4b. City, Town, or Location of Death BALTIMORE CITY				4c.	ath	
2	Funeral		5. Social Security I		6. Sex		7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da			rthplace (State or Foreign ountry)
	Director		168-24- Usual Residence		1 □ M	2 🔀 F	82	Yrs.				09/02	/1929		GERMANY
	and show 1 at	jo.	10a. State	10b. County			10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Maryl 28a-f otifiec	Director	MD	N,	/A			BALTIN	4ORE						1X Yes 2 No
	h the la or i	al D	10e. Street and Nu	ımber					10f. Zip Code				10g. Citi	zen of What C	Country?
	th with ms 23 must must	Funeral		ARK HE						215	1-1-0 (0	if. Vos or No		USA	
10	r dea	by Fu	 Marital Status Never Mai 	rried 2X Ma	ried 12. V	Vas Deced irmed Ford Yes	lent Ever in U.S ces? a \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Or an, Mexica	n, Puerto F	Rican, etc.)		 Race - Am Black, Whi 	
036	s afte ral", c Exan	q pe	3 Widowed		, If	Yes, Give			1 ☐ Yes 2X No	Specify	c:		\$	Specify: W	HITE
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified a	Completed	(Sp	15. Decede	nt's Education				dent's Usual Occup		st of workin	na	16b. Kir	nd of Business	s/Industry
121	within 73 giene. ier than i, the Me	yom (Elementary/Sec			ollege (1-4	4 or 5+)	life. D	O NOT use retired)			.5		OUNT HO	ME
	500.5											ME			
lan	SOLLY GOLDWASSER MIRIAM UI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z											NKNOWN			
Maryland	should and N is ma		19a. Informant's N	lame/Relations	hip (Type, Pi	rint)		19b. Maili	ng Address (Street	and Numb	er or Rural	Route Numb	er, City or	Town, State, Z	(ip Code)
	and 2 s Health tem 27			MARKO	/ITZ/H	USBAI				GHTS	AVEN	UE, #20			RE, MD 21215
Baltimore,	ge 1 a it of H : If ite or oth			Cremation		oval from S	State	cemetery, crei	osition (Name of matory or other plac			ate		cation - City o	
Ħ	permit. Page 1 Department of Important: If i any injury or once.			5 Other (AGU		ISRAEL CE			5/2011		ALTIMO	
Ba	permit. Departr Imports any inju		21. Signature of B	AHI)	M	an	H/22		2. Name and Addre 3900 REIS						., INC. MD 21208
			23a. Part 1. Enter	the disease, o art failure. List	r complication	ons that ca	aused the deat		er the mode of dyin					, , ,	Approximate Interval Between
	Physician/		Immediate Cause	(Final	,		_	RATOR	+ FAILUR	E					Onset and Death
	Medical Examiner		resulting in death)		f a		r as a consequ								9
		ē	Sequentially list conditions, If any, leading to immediate b. RECURRENT ASPRATION Due to (or as a consequence of):									20 Days			
	red	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Cause (Disease or												
	executed an and rial-transi		that initiated even resulting in death		C		or as a consequ	uence of):							
90		Physician/Medical			d										ļ
68760	death certificate be ne attending physici ed for use as the bu	/Me	IF FEMALE:		020 1	i uga guta	erre of progre								
Box (eath certifice attending p	cian,	23b. Was deceder in the past 12	months?	1	Live B	ome of pregna Birth 2 Feta ant at time of a	aldeath 3	Ectopic pregnand Other (specify)	Су			4413	23d. Date of d Month	elivery Day Year
B	t the dea by the a stached	hysi	1 Yes 2 9 Unknow			Unkno		doatii 3 L							
P.O.	ires that t signed b d be deta	oy P	_						underlying cause gi	ven in Part	: I.	23e. Did	tobacco u	se contribute	to the cause of death?
ds,	requires been sig should b	ted	CHRONIC			ease	, bkea	ST CAN	icer,			1 🗆	Yes 2	1 No 3 □	Probably 4 Unknown
Division of Vital Records,	law rei	nple	AORTIC	STEMO	SIS,	DIAB	seres	WITH	neuro Pat	THY.		24a. Was	psy	prior to	utopsy findings available completion of cause of
Re	CHRONIC KIONEY DISEASE, BREAST CANICER, AORTIC STENIOSIS, DIABETES WITH NEUROPATHY 24a. Was an autopsy performed? death? 1 Yes 24 No 1 Yes death?										es 2 No				
ital	s ician: The certificate irector, pag) Be	25. Was case referexaminer?		Hospi	tal:			Oth	or.	ath (Check				
of V	Physer this eral di	e: To	27. Manner of Dea		_ 2	8a. Date o		28b. Time o	nt 3 □ DOA DOA 28c. Injur	4 <u>N</u> y at		me 5 ∐ Res 28d. Describe		Other (Spe	ecify)
uc	nding Fath. r: Atter ne funer	icat	1 ☐ Natural 2 ☐ Accident	5 Pendi Invest	ng igation	(Month	n, Day, Year)	injury	M 1 🗆	₹? Yes 2 [] No				
Visi	Part II. Other significant conditions contributing to death but not the property of the proper								reet, factory, office				Street and	Number or R	ural Route Number,
Ö	pital o				-	T 11 - 1 -		J- 1 14b	and the time	- 1-1	1	I to a to allo	,		
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in the	Medical		2 Medical	Examiner: C	n the basis	s of examinatio	n and/or inves	occurred at the tim stigation, in my opinion, death occurred at	on, death c	occurred at	the time, date	and place,	and due to the	e cause(s) and manner stated.
	To the virthin To the comp	2	29b. Signature and	title of certifie	r			my knowedge	29c. Licens	e number		50, 4112 430 10		e signed (Mor	
			▶ She	malan	e Cros	1	mbbs		RES	- 00	Ö		SEPTI	ember	15 , 20li
ζ			30. Name and add		who comple	eted cause			Print) HOSPITA	2 0	F 8	ALTIM	SRE.		
	Stat		31. Date filed (Mon		6		gistrar's Signa						130		
	Registra	ar	DEL TO	CUII /	com	1 1	7	1277							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:35 pm 9-Hrleuo Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A **Examiner** 4b. City, Town, or Location of Death Joseph Ritchie Hospice Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours 0272171945 Maryland 214-44-0291 **Director** 66 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be Funeral 23a 21217 U.S.A. 2 N. Smallwood St. Apt 217 items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mea gines. Elementary/Seconday (0-12) College (1-4 or 5+) Self 12th Grade Hairdresser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jessie Unk Welden Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1825 N. Monroe St., Baltimore, MD 21217 Eugene Smith(son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 \square Burial 2 \bigcirc Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) cemetery, crematory or other place) Baltimore, MD on-site Crematory 09 21. Signature of Funeral Service Licenses 子心罗色的什么种s. of Berown Jr. Funeral Home PA tuch 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to lor as a consequence of attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) detached g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform certificate ARlene 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Harry 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify 6 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Balt 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State

Registrar

6

0)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-06851 State of Maryland / Department of Health and Mental Hygiene Benjamin Nichols 1- For State Certificate of Death Reg. No. Registrar 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day Y September 11, 2011 1440 hrs Medical Examiner Benjamin Nichols, Jr. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Maryland General Hospital **Baltimore** N/A 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs 7. Age (In yrs, last birthday) **Funeral** Days Months Hours Min 215-86-5198 Director Country) 1² M 02/15/1975 36 Usual Residence of Deceden 10d. Inside City Limits any 10a State 10c. City, Town or Location 1 Yes 2 No MD N/A items 23a or 28a-f show Baltimore Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 721 Newington Ave. 1st Fl. 21217 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. must be Armed Forces? 1 Never Married 2 Married Yes 5 Specify: Black 1 Yes 2 X No specify 3 Widowed 4 Divorced If Yes, Give Yea If item 27 is marked other than "natural", 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical 10th Grade Unemployed N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin Nichols Sr. Be Alice Bowens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice Bowens (mother) 721 Newington Ave. 1St Fl., Balto., MD21217 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State crematory or otterpenia tory Baltimore tment o 09/20/11 -site Cmemator Waltimore, MD Donation 5 Other Specify. 6 21-Slanafüre of Funeral Service Licenses Funeral Home PA Fulto Joseph H ton Ave., Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death a Pulmonary Thromboembolism Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) b. Deep leg vein Thrombosis Sequentially list conditions, Due to (or as a consequence of) Examiner If any leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - tran AMENDED, 20b,c,22 per fh g919 9-16-11 vt Item # 1 as noted,23a-b,27,per me,g920 Physician/Medical X UNPENDED 10-24-11 The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Month Year 1 Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? ✓ Yes 2 No death? 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural Yes 2 No 5 Pending d in by the f Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be (Specify) To the Funeral 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. September 12, 2011

0

Registrar

DHMH 17 Rev 1/2001

OCME 2006

State

30. Name and address of person who completed cause of death (tiem 23a)

Russell Alexander MD

31. Date filed (Month, Day)

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

amend #19a Per FH G919 9/28/2011 JH

State of Maryland / Department of Health and Mental Hygiene

1 - State amend item 19a per fh g920 10-5-11 vt

Registrar

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Year Sept. 7:45P. Christian U. Oparah Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day, Year)

Oct. 15, 1947 Social Security Number 9. Birthplace (State or Foreign Country) Nigeria 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F 544-94-8274 **Director** 63 Yrs. Usual Residence of Decedent 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho; any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3109 Glenmore Avenue 21214 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Nigerian 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Donmic Oparah Abiahu Oparah 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugena Maureen Philip - Wife 3109 Glenmore Avenue, baltimore, Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of Oparaly), Family by other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 9-23-11 4 ☐ Donation 5 ☐ Other (Specify) Owerri, Nigeria Burial Ground . Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009 Harford Road, Baltimore, Maryland marguelle 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician/ Archu disease or condition Due to (or as a consequence of Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (orsease or in jury that initiated events resulting in death) Last Examine Due to (or as a consequence of) nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending achieving Division of Vital Records, P.O. Box 68760 use as 1 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year signed by the at id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has autopsy perform 2 🗌 No 1 Yes 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No ည 1 Inpatient 2 PR/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: Natural 2 Accident 5 Pending Investigation completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Deertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) phy 5igo ton bor 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Od 210 5601 Loch Raven Blvd Balto. MD 21239 31. Date filed (Month, Day, Year 32. Registrar's ggnature State 1 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29647 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5:00A [™] HELEN A. PIELERT 2011 SEPT Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore 11811 Franklinville Rd. Upper Falls 8. Date of Birth (Month, Day, Year)
Nov. 24, 1936 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 212 32 4353 Maryland Director 1 □ M 2**X**XF 74 Yrs or 28a-f shov notified at show 10d. Inside City Limits 10a. State 10c. City, Town or Location Director White Marsh 1 Yes 2 No Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any njury or other traumatic event, the Medical Examiner must be a once. Funeral 21162 USA 10520 Vincent Farm Lane 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 🗶 No Specify. White If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) N/AHomemaking-Own Home ll yrs. <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Helen Cioka Bernhardt Zybell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 10520 Vincent Farm Lane White Marsh, Md. 21162 John J. Pielert (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-17-2011 Baltimore. Maryland of Faith 21. Signature of Funeral Service Licenses ^{Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 83 Lassels 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phinician/ metastatic mos. disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 Yes 2 l filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 POther (Specify) Sm's house 1 Yes 2 LINO 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of al or Attending Plaster death. 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital o within 24 hours aff To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20040850 September 14,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9103 Franklin Synme Drive Baltomin Maryland 21237 VONNE OTTAV, AND MA 31. Date filed (Month, Day, Year) SEP 1 6 2011 32. Registrar's Signature State Registrar

2011

7 - 7

0

2

11-06791									
David	Pr	eston							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day September 8, 2011 Medical Examiner 0000 hrs avis 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 5026 Erdman Avenue Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreian Months Director 40 Country) 1 M 2 F 10d. Inside City Limits 10a State 10c. City, Town or Location Iny 10b. County 1 Yes 2 No dother than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 0 Funeral 11. Maritel Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes White 1 Yes 2 No specify: 4 Divorced If Yes, Give Year Specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 of Health and Mental Hygiene. 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KEEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R. ral Route Number, City or Town, State, Zip Code) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 2 Cremation 3 Removal from State materi 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee - ASKTON Eunera Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ried Between Onset and failure. List only one cause on each line /Medical Death Immediate Cause (Final disease *Narcotic Intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED23a, 27, 28a-f, per me, g919 9-28-11 smed by the attending physician a detached for use as the burial -Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the 1 Live birth Year 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be deta ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natural Pending 1 Yes 2 No fd 9-8-11 fd 5:45 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be or Town, State) 5026 Erdman Ave determined residence Homicide Baltimore, Md 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 9, 2011 he hame and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 29649 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William R. Porter 11, 2011 9:05 PMSeptember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Ingleside at King Farm Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 24, 1929 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 1 X M 2 □ F 214-26-0883 82 Maryland **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Rockville Maryland Montgomery 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 701 King Farm Blvd. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed Specify: White 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Montgomery County life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Public Schools Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Virginia Rollins Jefferson D. Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 701 King Farm Blvd., Rockville, Maryland 20850 Margaret H. Porter/Wife Date 15, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery Crematorium, Inc. 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Days Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Years Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi): physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Hypertension Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 nding p nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hyperlipidemia 1

Yes 2 □ No 3 □ Probably 4 □ Unknown should Parkinson's Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🛛 N 2 🗆 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Assisted city) Living Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) ၉ 1 Yes 2 XNo 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 X Natural Accident Investigation 24 hours after deatl Funeral Director: filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) မ D34590 September 13, 2011 Ici n

State Registrar

parke

7758 Wisconsin Avenue #211, Bethesda, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Roy Fried, M.D. 31. Date filed (Month, Day, Year,

SEP 1 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 14 2011 Physician/ Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death 2 Hospice low SON **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Davs Hours Min. Country) Director 1 🗆 M 2 💀 F or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location **Funeral Director** 1 Yes 2 No MARYLAN & 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 █ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and Mental Hygiene.

is marked other than "natural", raumatic event, the Medical Exal 1 Yes 2 No Specify: If Yes, Give Specify: WhiTe 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOME should be filed v and Mental Hyg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ဂ္ PARKS Department of Health and Ment Important: If item 27 is marked any injury or Att JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVENUE BALTIMORE (SON) 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Lice 22. Name and Address of Facility · ICHOJNACKIFAN DABROWSKI Dundalk Are Baltimore. 23a. Part 1. Enter the disease, or complications to shoot, or heart failure. List only one cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HRUNICOBSTRUCTIVE PULMENARY disease or condition PARC Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnap 23d. Date of delivery in the past 12 month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CCRUNARY ARTERY DISPASE Records, To the Hospital or Attending Physician: The law requires 1 les 2 No 3 Probably 4 Unknown Z DIABOTES ME LLITUS 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? 1 Yes 2 146 Division of Vital completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Tes 4 Nursing Home 5 Residence 6 other (Specify) HOSPIC & 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. I*n*jury at work? 28d. Describe how injury occurred 1 Natural 5 Pending after death, Director; Aft 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a To the Funeral I Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge death promise at the time, date and place and due to the realists) and manner stated Certifying Nurse Practitioner: To the best of my knowledge death promise at the time, date and place and due to the realists) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

SEP 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 29651 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O Month Physician/ 5:20 AM 2011 Medical Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4h City 4c. County of Death sardens *Lesvi* 7 MOZO Sex 1**V**LM 2 □ F 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year **Funeral** Months Hours Min. Country) April Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director Yes 2 \ No Hmore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Was Deceue... Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie. Important: If item 27 is marked other tany injury or other traumatic event the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nillios ဂ္ mma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 2207 rrie α athma Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date crematory or other pla altimero 21. Signature of Funeral Service Due 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown signed by the 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗌 No Yes 2 N Yes Vital or Attending Physician; 25. Was case referred to medica filled in by the funeral director, Medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Division death. 1 Yes 2 🗆 No 2 Accident
3 Suicide Investigation Director 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide the Hospital within 24 hours

To the Funeral I Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifi ess of person who completed cause of death (Item 23a) (Type, Print) MargaretCorporar CRNP 600 Marshallee Dr. State Registrar

DMO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August Physician 3 Pay 201°1 3:07 Рм Mary Ryan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Manor Care - Dulaney If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 5, 3, 1, 921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) unk **Funeral** 1 □ M 2 X F 90 Director 282-14-5518 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show then tranmatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Baltimore Towson Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 USA by Funeral 111 West Rd. 12. Was Decedent Everin U.S. Armed Forces? UTIN U.S. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation un 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Carroll - guardian 145 N. Hickory Ave; Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4□Donation 5XiOther (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signa We of Funeral Service Linese Bound 655 W. Baltimore St; Baltimore, MD 21201 23a. Part1. Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final **Physician** CEREBROL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner JTROK Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit the death certificate be executed Due to (or as a consequence of): Physician/Medical attending plant 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perforn After this certificate 2 **X**No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Dath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, P.O. Box 68760, or Vital

To the Hospital or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the

Medical

29a. Certifier

(Check only one)

29b. Signature and title of

State Registrar

1 Y ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) D-12849

Name and Iddress of person who completed cause of death (Item 23a) (Type, Print) OSLER Dr. Towson MD 21204

31. Date filed (Month, Day, Year)

and manner stated.

back

11-06284 Allen Roberts Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

16.	0	1	
	U		

29653

		1- For State Registrar			Certif	icate of L	Death		F	Reg. No.	
Physic		1. Decedent's Name (Fir	rst, Middle,Last)					2. Date of Dea	ath	3. Time of Death
Medical Exam	nine	Allen Rob	erts						Month August 20	Day Year 0, 2011	1955 hrs
		4a. Facility Name (if not	institution, give	street and number		4b	. City, Town, o	r Location of D		4c. County of Dea	ath
		Harbor Hospital	l Center			İ	Baltimore				
Funera	1	5. Social Security Number	eunk 6. Se	x 7. Ag	e (In yrs. last I	birthday)	If Under 1 Ye	ar If Under 2	4Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. E	Birthplace (State or
Directo	r		1X	M 2 F	69	Yrs.	Months Da	ys Hours	Min. April	27, 1942 For	eign CountryNew York
	1	Usual Residence of Dec				110.					.,
* Dy			County		10c. City, To	wn or Location	1				10d. Inside City Limits
A	۱.	MD			Ba1t	imore					1 X Yes 2 No
Aaryland 28a-f show	Director	10e. Street and Number					10f. Zip Code		1.	10g. Citizen of What Co	
Mai	Ē	1836 Lig					2123	Ω		USA	out to y?
death with the Maryland or items 23s or 28s-f sho must be notified at once.											
th wi	Funeral	11. Marital Status 1 Never Married	2 Married	Was Decedent Armed Forces?					(Specify Yes or No erto Rican, etc.)	0- 14. Race - Am White, etc.	erican Indian, Black,
					X No		_		,		
s afte	≦	3 Widowed 4		If Yes, Give Year or Dates:			es 2 X No			Specify: Wh	
hour natu	8	15. Decedent's Educati						ation (Give kind e. DO NOT use		16b. Kind of Busines	s/Industry
136 hin 72 hours af e. than "natural"	Completed	Elementary/Secondary	y (0-12)	College (1-4 or	b+)					1	
withi withi yiene	l E	8 17. Father's Name (First,	M: (0. 1 0.	0		paint	er	40.14			nprovement
filed Hygel	Š			-b C					ame (First, Middle,		
21215-0036 und be filed within 7 Mental Hygiene. marked other than event, the Medica	o Be	19a. Informant's Name/R		oberts Sr		40h Mailian A	44 101		Maude C		
	ļ۴	Joyce Bel			ł		-			mber, City or Town, Sta ${f e}$, ${ m MD}$ 21222	
MD and 2 shot and 2 shot and 27 is	1	20a. Method of Disposition		212661	20h Plac	e of Disposition			Date	20c. Location - City	
S 1 a of He ist		1 Burial 2 C		Removal from Sta		natory or other		metery,	Date	200, Education - City	or rown, state
Page Page nent of the percent of the		4 Donation 5 X	1 -	_							
Baltimore, oernit. Pages I ar Department of Hee Important: If ite		21. Signature of Euneral			ector					tomy Board	
m 89 4 8		-com	////	VV	-	65	55 W. B	altimo	e St; Ba	ltimore, MI	21201
Physiciar		23a. Par J. Enter the dise failure. List only on	ease, or compli	cations that caused	the death. Do	not enter the	mode of dying	, such as cardi	ac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
/Medica		Immediate Cause (Final		leroin Intoxicat	ion						Death
Examine	1	or condition resulting in o		ue to (or as a conse	equence of):						
		Sequentially list condition	ns, b								
	횰	if any, leading to immedi- cause. Enter Underlying	iate D	ue to (or as a conse	equence of):						
	Ē	(Disease or injury that in	itiated C_	ue to (or as a conse	equence of):						
ecuted and transit	E	events resulting in death) Last Due to (or as a consequence of): d.									
execut an and al - trau	<u>8</u>	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delive								+	
760, ficate be exc g physician of the burial -	<u>8</u>	IF FEMALE:								004 0-4-4 4-1	
876 ificat ng ph	\geq	23b. Was decedent pregn	nant in the	23c. If yes, outcor	ne or pregnanc	2 Fetal	death 3	Ectopic pre	egnancy	23d. Date of delive Month	Day Year
ox 68 eath certi attending	<u>:8</u>	past 12 months?			time of death		(Specify)				
Box 68; c death certificate attending ed for use as 1	Physician	1 Yes 2 No 9	Unknown	9 Unknown						1 _	
at the		Part II. Other significant	t conditions	contributing to death	but not result	ting in the und	erlying cause	given in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
, P.O. res that the signed by be detac	d b	Cirrhosis of the	Liver, Hype	ertension					1 Ye	s 2 🗸 No 3 🗌 Pr	obably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirer as after death. at Director: After this certificate has been sifed in by the fineral director, page 2 should be led in by the fineral director, page 2 should be	Completed								24a. Was		autopsy findings available
COI law has I	글			·					autor	rmed? death?	completion of cause of
tal Re	S									2 No 1 🗸	Yes 2 No
certification certification certor.	Be	25. Was case referred to examiner?		ospital:				e of Death (Che			
Physical directions of the second direction directions of the second direction directions of the second direction directions of the second direction directions of the second direction direction directions of the second direction direction directions of the second direction directi	2	1 ✓ Yes 2	No	· 1 Inpatie	nt 2 🗹 ER/					Residence 6 Oth	er:
I Of ing P After funera		27. Manner of Death 1 Natural 5		28a. Date of Inju FOUND:	ry 28t	o. Time of Injui DUND:		ry at Work?	28d. Describe Subject Use	how injury occurred	
ttend Heath.	l ij	2 Accident	Pending Investigation	A 00 0044		15 hrs	1 1	Yes 2 🗸 No			
or A or A offer of pires	<u>E</u>	3 Suicide 6	Could not be	28e Place of In	ury - At home,	farm, street, f	factory, office I	building, etc.	28f. Location (or Town, S		Rural Route Number, City
B B B B F F F F F F F F F F F F F F F F								1836 Light St	reet, Baltimore, MD	<u> </u>	
24 h		(Silvert Silvery								se(s) and manner as sta	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, (check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature and tilte of certifier							, in my opinior	n, death occurr	ed at the time, date	and place, and due to	the cause(s)
	Ž	29b. Signature and tille o	of certifier	0/11	A 92 H	/	29c. Licens	e number		29d. Date signed (M	onth, Day, Year)
		Trothe	1/1/15	- Hoch	1700		O.C.	M.E.		August 21, 201	1
30. Name and address of person who completed cause of death (Item 23a)											
		Victor Weedn M		sistant Medical		•	Baltimore S	Street, Balti	more, MD 2122	23	
	tate	31. Date filed (Month, Da)	yaream nn-	32 Registrar	's Signature	Jank					
Regis		2FF.	T D ZUI	Leneur	J B.	Man Charles	-				

11-06724 Alexander Ruffin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011 29654

charact run				Certificate of Death	Reg. N	
Physic	rian		istrar Decedent's Name (First, Middle,Last)		Date of Death Month Da	3. Time of Death
ledical Exan		4	Alevander Ruth	0	September 6	, 2011
			Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	n	4c. County of Death
			St. Agnes Hospital	Baltimore		NIFF
		5		yrs. last birthday) If Under 1 Year If Under 24Hr	s. 8. Date of Birth (N	MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Funera Directo		3	20-104-7341 1VM 20F	52 Yrs. Months Days Hours Mi	March 21	
	7	<u> </u>	ual Residence of Decedent	City, Town or Location		10d. Inside City Limits
any		10	a. State 10b. County 10c.	City, Town of Eccation		1 Lyes 2 No
pu show	텔 :	<u>-</u>	MD NIA	baltimore		Citizen of What Country?
Maryland 28a-f show	tified at onc	ğ 1	e. Street and Number	10f. Zip Code	10g.	Citizen of What Country!
or 2		<u> </u>	917 Edmondson Al	R 21229		USA
vith t			Marital Status 12. Was Decedent Ever	r in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
ath v	must be notified at once.		Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerl	O Ricall, etc.)	Disak
L -	. 1 1		Widowed 4 Divorced If Yes, Give Year A 2			Specify: Black
0036 within 72 hours after death with the Maryland joine. her than "natural", or items 23a or 28a-f Sh	ŭ .	∂⊢	15. Decedent's Education (Specify only highest grade complet	ed) 16a. Decedent's Usual Occupation (Give kind o		6b. Kind of Business/Industry
t hou	Exa .	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	A .	11.1.1.1
36 hin 73 e. than	dical -	亂	12	Medic terso	snel	Medical
with with	Me Me	틹	Father's Name (First, Middle, Last)	18 Mother's Nar	ne (First, Middle, Mai	iden Surname)
4 F F F F F F F F F F F F F F F F F F F	ᆁ (Be	Hexander Kuttin	Sr Luc	1 Will	36n
21215-0036 and be filed within 7 Mental Hygiene.	5	8 1 0 1	Pa. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number of	r Rural Route Number	er, City or Town, State, Zip Code)
MD 2 d 2 show lith and i	ر ي غ		-ucy Morton	3917 Edmonds	son Ave	Balto MD 21229
e, MC l and 2 sh Health an	or other traumatic		Da. Method of Disposition	20b. Place of Disposition (Name of cemetery,	Date 2	20c. Location - City or Town, State
of H	F F		De la companya de la	crematory or other place)	19 2011	DIMITOR Mills MIN
Pag ment	9	L	Dentation 5 Other Specify:	22. Name and Address of Facility		Thomas Hone
Baltimore permit. Pages 1 a Department of He Important: If it	E	13	1. Sonoticre of Funeral Service Moansee	1 11 was liberte	DWELL!	Ave, Batto MD
шады	ŗ	2	3a. Part I. Enter the disease, or complications that caused the	death. Do not enter the mode of dving such as caldia	or respiratory arrest	
Physicia		- 13	failure. List only one cause on each line.			Between Onset and Death
/Madic Examin	_		mmediate Cause (Final disease a Ethanol and Heroi			
		- 1	or condition resulting in death) Due to (or as a consequence)	ence of):		
		_	Sequentially list conditions, flany leading to immediate Due to (or as a consequ	ence of):		
		흘	auso Enter Underlying Cause			
	╗		Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conseque	ence of):		
uted	- transit	Ω	d			
'60, ate be executed	ed for use as the burial - tran	edical	UNPENDED AMENDED		_	
60, ate be	Par	§	F FEMALE: 23c. If yes, outcome	of pregnancy		23d. Date of delivery Month Day Year
87 tiffica	as th		3b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pre	gnancy	Month Day Year
X 6	Luse	Ö	4 Pregnant at tin	Other (Specify)		
cords, P.O. Box 687 law requires that the death certific	ed fo	Physician/	5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	the underlying cause given in Part I	23e. Did tob	pacco use contribute to the cause of death?
	d be detached f		Part II. Other significant conditions contributing to death b	ut not resulting in the underlying cause given in tack.		2 No 3 Probably 4 V Unknown
Greet the state of	bed	d by				
require	hould	를			autops	prior to completion of cause of
e law	3e 2 s	Completed			perform 1 ✓ Yes 2	
8 = 1	r, pag		25. Was case referred to medical	26 Place of Death (Ch	eck only one)	
ician	recto	Be	examiner? Hospital: Inpatient	2 ER/Outpatient 3 DOA Other No	ursing Home 5 F	Residence 6 Other:
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the state of the death.	After this cettificate has been a funeral director, page 2 should	유	77 Manner of Death 28a Date of Injury	28b. Time of Injury 28c. Injury at Work?		ow injury occurred
O L	lu g	崩	1 Natural 5 Pending FOUND:	fOUND: 1 Yes 2 V No	Unknown	
Sior vittend death	y the	ä	Sep 6, 2011	1705 hrs ry - At home, farm, street, factory, office building, etc.	28f. Location (S	street and Number or Rural Route Number, City
or A	Director: I in by the	ij	3 Suicide 6 Could not be		or Town, St 3917 Edmond	tate) son Avenue, Baltimore, MD
Dours	filled in by the	Certification:	4 Homicide determined (Specify) Four			
Division of Vital To the Hospital or Attending Physician: within 24 hours after death	e Fur	Sal	29a. Certifier 1 Certifying Physician: To the best of my light Certifying Physician: To the basis of examiner On the basis of examiner.	knowledge, death occurred at the time, date and place, nation and/or investigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
ithin	To the Fun completely	Medical	and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)
H 3 F	ر ا	ž	29b. Signature and title of certifier			September 7, 2011
			(arol Halox	O.C.M.E.		Coptember 7, 2011
3			30. Name end address of person who completed cause of de	ath (Item 23a)		
			Carol Allan, MD Assistant Medical Exam	iner 900 W. Baltimore Street, Baltimore	e, MD 21223	
	s	tate	31. Dete filed (Month, Day, Year) 32. region of	s Signatury Barks		
Re	egis		CED 1 6 2011 / Museum	J. Maire		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marie September 2011 4:00 Rigney Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A 3715 Echodale Avenue Baltimore 8. Date of Birth (Month, Day, Year) June 29, 1 g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under Social Security Number 6. Sex **Funeral** Maryland Months Hours 1 🗆 M 2 💢 F Director 216-30-5137 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1x Yes 2 No Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21206 U.S.A. 3715 Echodale Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 10th. Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) С. Heffernan Ray Martin Sarah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Philip Rigney/Husband Baltimore 3715 Echodale Avenue MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 09/17/2011 MD 4 Donation 5 Other (Specify) Glen Burnie Atlantic Crematory 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility
Miller-Dippel Funeral Home,
6415 Belair Road Baltimore 21206 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a Part 1 Enter the disease shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final disease or condition Procond Physician/ Medical resulting in death) **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 p onth 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 26. Place of Death (Check only one, Be 25. Was case referred to medical examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier mo 00028673 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Charles Street, Swite 425

01

State Registrar

DHMH 17 Rev 7/2009

FRIEDLANDER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g919 9-16-11 yt State of Maryland / Department of Health and Mental Hygiene for State Registrar 29656 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ september 11, 2011 3:20 Jeanne Elyse Renton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 816 Bynum Run Court Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country/Florida 1 □ M 2 🗶 F Days Hours Min. Feb. 25, Year 1927 Director 84 203-20-5230 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 🎽 No Lake Placid Florida Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1244 Lake Clay Drive 33852 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black White etc ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Public Education Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Esther Virginia Gabbert injury or other traumatic Richard Eugene Livingston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Bynum Run Court, Bel Air, Maryland 21015 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is n Deb Renton / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 9-14-11 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ stive Hear nowhs disease or condition Medical resulting in death) Due to (of)as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner death certificate be executed Cause (Disease or linjury arana that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 s, outcome of pregnancy Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1
Yes 2 24a. Was an autopsy has page 2 this certificate 25. Was case referred to medió examiner? Division of Vital 26. Place of Death (Check only one) Be daughter's Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 6X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending Pt in 24 hours after death. The Funeral Director: After the pleted filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniurv 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed ca se of death (Item 23a) (Type, Print) IOV State 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 5:15A 2011 Sept. 11 Esther Ε. Ross- Matthews Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Future Care Sandtown 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 6. Sex **Funeral** Country)VA 11-11-13 1 🗆 M 2 🔀 F Days Hours Min 212-05-8184 97 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director X X Yes 2 □ No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 524 N. Charles Street Apt. USA 21201 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. African ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: American | Hygiene. other than "natural", 3 X Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waxter Center NĂ 8th Grade Secretary Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ္ Lendora Ourthur Ross permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1103 McKean Avenue Baltimore, MD. 21217 Tiffany Matthews-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State MD. Nat I Cem. 09-16-11 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. . Signat re of Funeral Service Licenseé 22. Name and Address of Facility MD 21217 Gilmor Street Baltimore, 638 Ν. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a nee of) Examiner Sevientially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a cons To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No death? 1 Yes 2 No certificate To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4X Nursing Home 5 - Residence 6 - Other (Specify) Hospital 2X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. hours after death. М 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: Teste best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 09-13-11 500

Registrar
DHMH 17 Rev 7/2009

State

32. Registar's Signatur

Antwi, MD, Linden Medical Group 1501 W. Mt. Royal Ave.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Owusur

Kosi

SEP 1 6 2011

11-06896 Raymond Rosen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 1 1 29658 State of Maryland / Department of Health and Mental Hygiene

		i- For State Registrar		Certif	icate of L	Death				eg. No.		
Physicia Medical Exami	ın/	Decedent's Name (First, Middle,Li RAYMOND	ast) MYLES	ROSEN				2	Date of Dea Month Septembe	oth Day Yea er 12, 2011		3. Time of Death 2320 hrs
		4a. Facility Name (if not institution, g			4	. City, Town, or Baltimore	Location o	of Death		4c. County of	of Death	
Funeral Director				In yrs, last 74	birthday) Yrs.	If Under 1 Year Months Day	_		8. Date of Bi	rth(MM/DD/YYYY 3, 1937	Foreign	nplace (State or n MD ntry)
Aaryland 28a-f show any 1 at once.	ă	Usual Residence of Decedent 10a. State 10b. County MD N/A	1		wn or Location							10d. Inside City Limits 1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once	Director	10e. Street and Number 6320 GREENSPRI	NG AVENUE #	102		10f. Zip Code 21209	1			10g. Citizen of Wh	at Count	try?
iter death ", or iter	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce 15. Decedent's Education (Specify	1 X Yes 2 ed If Yes, Give Year or Dates:	No No	If Yes	Decedent of His, specify Cubar (es 2 X No	n, Mexican, o s <i>pecify:</i>	Puerto R	ican, etc.)	14. Race White Specify:	e, etc.	
5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	st of working life ED PUBI	DO NOT	use retired	d)	ACC	DUNT	ING
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medical	Be Com	17. Father's Name (First, Middle, La EMANUEL	st)		ROSEN			CEL	ESTE	Maiden Surname FL	AX	
MD 21 2 should in and Mer 27 is man	2	19a. Informant's Name/Relationship HARRIETT ROSEN			19b. Mailing A 6310 G	Address (Stre REENSPI	et and Num RING A	AVE,	#301;			Zip Code) MD 21209
Baltimore, MD 2's permit. Pages I and 2 should Department of Health and M Important: If item 27 is minjury or other traumatic e		20a Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Special		20b. Place	ce of Disposition That or of other TISRAE	Disposition (Name of cemetery, of of the parties of cemetery) SRAEL 9/15		9/15/	Date 2011	20c. Location - Baltim		
Balti permit. Departu Imports		21. Signature of Funeral Service Lice	ensee Alla		890	me and Addres	TERST	OWN R	D: BAI	SON & BRO	MD	21208
Physician Medical		23a. Part I. Enter the disease, or confailure. List only one cause on Immediate Cause (Final disease			o not enter the	mode of dying	, such as c	ardiac or r	espiratory ar	rest, shock, or he	art	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conseq									
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseq c.									
ecuted and transit	_ !	events resulting in death) Last	Due to (or as a conseq		fh c01	19 9–16	_11 ,,,	+				
760, icate be executed physician and the burial - transit	Medica	IF FEMALE:	AMENDED 20 23c. If yes, outcome							23d. Date of	_	
Box 687 death certific he attending de for use as to	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	1 Live birth 4 Pregnant at ti 9 Unknown	me of death		Il death 3 er (Specify)	Ectopio	e pregnand		Month	D	ay Year
, P.O. B ires that the d signed by the		Part II. Other significant condition Emphysema	s contributing to death	out not resu	ulting in the un	derlying cause	given in Pa	art I.				the cause of death? ably 4 Unknown
cords law requi has been 2 should	Completed by									psy I		topsy findings available ompletion of cause of
ital Rec sician: The s certificate irector, page	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatien	2 EF	R/Outpatient		Other4	·		Residence 6	✓ Other	: Scene
on of Virunia Physath. or: After this	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	28a. Date of Injury FOUND: Day, Yes	/ 28 ar) F	8b. Time of Inj OUND:		ury at Work	? 2	8d. Describe	how injury occur	red	vater in bathtub
Division Hospital or Attened Hospital or Attened When after death Funeral Director: Stely filled in by the	Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide	ot be 28e. Place of Inju	ry - At hom	e, farm, street	, factory, office	building, et		or Town.	State)		ral Route Number, City , Baltimore, MD
To the Hospi within 24 hou To the Fune completely fil	Medical C	29a. Certifier 1 Certifying Phys	sician: To the best of my ner:On the basis of exam and manner stated.	knowledge, ination and/	death occurre or investigation	ed at the time, on, in my opinion	date and pla n, death oc	ace, and d	lue to the cau the time, date	use(s) and manne e and place, and o	r as state due to the	ed. e cause(s)
5 .2 5 8	We	29b. Signature and title of certifier	and manner stated.				se number .M.E.			29d. Date sign Septembe	,	
7		30. Name and address of person who Donna M. Vincenti, MD	no completed cause of de Assistant Medica			V. Baltimor	e Street,	Baltime	ore, MD 2	1223		
St Regist	ate trar	31. Date filed (Morlin, Day, Year)	2011 32. Figishian	s Signature	bar	K)						
DHMH 17 Rev 1/2		JEF 1 U	OOME		ORIGINAL							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie en 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 08:06 M 09 2011 10 Stewart /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Pikesville Courtland Garden Nursing Home Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Hours 28 ٧A Director 214-24-6287 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural; or itams 23a or 28a-f show usy or other traumatic event. It is Nearland to notified an ury or other traumatic event. It is Nearland 1 Yes 2 No Director Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21207 U.S.A. 3202 Fairview Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Riley Manufactory Seamstress 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Be John Randall 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3202 Fairview Road, Baltimore, Md 21207 Brightley R. Stewart 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. Pikesville, Md 9/19/2011 Druid Ridge atur f Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to lir as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: Injury Division To the Hospital or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

bo

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and ad trees of person who completed cause of death (Item 23a) (Type, Print)

Parguret Corcoran CRNP

Registrar DHMH 17 Rev 1/2001 6095 Marshalfee Dr. Elknoge MD,

29d. Date signed (Month, Day, Year)

1-06402		Please Type or Print in Black Indelit State of Maryland / Departme	nt of Health and Mental H	voiene		20660
aura Steck		1- For State Certifica	te of Death		2011 a. No.	29660
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ledical Exami		Laura Steck		Month August 25,		1148 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Baltimore Cou	
		10100 York Road Room 200	day) If Under 1 Year If Under 24Hrs	8 Date of Birth	(MM/DD/YYYY) 9. Bir	·
Funeral Director		5. Social Security Number 1 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min	_	Forei	Pennsylvani
Billottor	-	Usual Residence of Decedent	Yrs.	11012 011 /	, -, -,	
ku a	- 1-	10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits
E	2	MD Baltimore Cocke	ysville			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code 21030	100	g. Citizen of What Cou USA	ntry?
eath with the Maryland items 23a or 28a-f sho ast be notified at once.	- 1	307 Lord Byron Ln.		if . Ven er No		ican Indian, Black,
th wit	Funeral	1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	White, etc.	ican indian, black,
er dea		1 Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: Wh	ite
2 hours aft "natural" Examine	ē e	15 Decedent's Education (Specify only highest grade completed) 16a. D	ecedent's Usual Occupation (Give kind of uring most of working life, DO NOT use ret	work done Unk	16b, Kind of Business	Industry
5 72 ho cal Ex	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	uting most of working life. DO NOT ase rec		Becton Dic	kingon
within iene.	Completed	12 2	18 Mother's Name		aiden Surname) Un	
17215-0036 Id be filed within 72 hours after d fental Hygiene. narked other than "natural", or event, the Medical Examiner m	Be Co	17. Father's Name (First, Middle, Last) unk	TO. MOUTON S MAIN	o (r not, mades, m		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Flygiene. 7 is marked other than "natural", or items 23a or 28a-f shratie event, the Medical Examiner must be notified at once	P B	19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or			
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and In Important: If item 27 is m injury or other traumatie	Ĺ	Edward Winkler - friend	6207 Marglenn Ave;			
Fe, land f Heal	- [Disposition (Name of cemetery, ry or other place)	Date	20c. Location - City o	r Town, State
Page nent o		4 Donation 5 Nother Specify: in State			Towns.	
Salt ermit. Departs mport		21. Signature of Funda Service Licens Konald S. W. 10, Director	22. Name and Address of Facility Sta 655 W. Baltimore	ite Anato St. Ralt	imore. MD	21201
Physician	\exists	23a Part I. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval
Wedicul		failure. List only one cause on each line.				Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Narcotics (Morphin Due to (or as a consequence of):	C/Intoxicación			
	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				+
	ij.	Cause. Enter Underlying Cause (Disease or injury that initiated				4
ed 18it	cal Examiner	events resulting in death) Last Due to (or as a consequence of):				
executed an and al - transit	g	MENDED ☐ AMENDED 23a, 27, 28a—	f,per me,g919 9-19-	ll sm		
	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	ry —
OX 687 eath certifics attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?		ancy	Month	Day Year
leath c e atten for us	/sic	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)			
that the deletached		Part ii. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		bacco use contribute to	
, P.	d by			1 Yes		obably 4 Unknown
ords, w requir s been s should	Completed	H		24a. Was a autops	sy prior to	utopsy findings available completion of cause of
Cecc	E			perform	med? death? 2 No 1 ✔	es 2 No
tal Receiptors	BeC	25. Was case referred to medical examiner?	26.Place of Death (Check			
Vit Physic r this o	T0 E	1 ✓ Yes 2 No Inpatient 2 ER/O	utpatient 3 DOA Other Nursi		Residence 6 Oth	er: Scene
n of ving Ph. After tl. After tl.		1 Natural 6 (Month, Day, Year)	1 Yes 2 T No	Unknown	ion injury cocurred	
Sior	cati	2 Accident Investigation 28e, Place of Injury - At home, fa	11:27 am rm, street, factory, office building, etc.	28f. Location (S	Street and Number or F	tural Route Number, City
Divis	Certification:	3 Suicide 6 X Could not be determined (Specify) Hote		or Town, St	tate)[0100 YO1 ville,Md.	rk Rd.Rm 200
Division of Vital Records, P.O. Box 68760, To the Hoppital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, an	d due to the cause	e(s) and manner as sta	ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.		at the time, date a		
	Ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (M August 26, 201	
		UMULE	0.0.WI.E.			
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 V	V. Baltimore Street, Baltimore, N	ID 21223		
s	tate					
Regis			barker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 11,2011 Barbara Jean Schott 11:56P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 4717 Mellow Road White Hall **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Days Hours 11-11-1938 Director Maryland 214-38-0146 Usual Residence of Decedent 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits or 28a-f White Hall Md. Harford 1 Yes X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or items 23a o by Funeral 21161 4717 Mellow Road USA and 2 should be filed within 72 hours after death. Health and Mental Hygiene. tem 27 is marked other than "natural". or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Blanche Starner Lowell G. Hash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4717 Mellow Road White Hall, Md.21161 Spouse Emil A. Schott 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Paul UMC Cem. 9-15-2011 Pylesville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 610 W. MacPhail Road BelAir, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DEMENTIA - ALZHEIMERIS disease or condition 10 Years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Year 2 No 1 ☐ Yes ∠ ≠ 9 ☐ Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? DiabetES 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ITYPER TENSION 24a. Was an this certificate has autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{Z}\) Residence 6 \(\sum \) Other (Specify) 1 ☐ Yes 2 💢 No ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100052292 9/13/201 com

lov

State Registrar SINDHU JAMES 7141 SECUR 31. Date filed (Month Day, Year) 37 neistrar's Signature SEP 16 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7141 SECURITY BLV1

BALTIMORE MID-21244

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5 1:05PM STARRELS EOR GE 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Aspen Hill Montgomery Layhill Manor Group Home Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 X M 2 🗆 F Director 89 Pennsylvania 204-12-1099 Usual Residence of Deceden shov 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** ems 23a or 28a-f sh r must be notified a 1 ☐ Yes 2 🕅 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 UŠA 10612 Glenhaven Drive "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 X No Completed by 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 🗆 Widowed 4 🗆 Divorced Year or Dates ed other than "natur event, the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Manufacturers Representative Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lewis Starrels Anna Ralph 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10612 Glenhaven Drive Silver Spring, MD 20902 Health tem 27 Rayna Starrels/wife other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date cemetery, crematory or other place)
Final Journey Crematory 09/13/11 ☐ Burial 2 X Cremation 3 ☐ Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Dementia Medical resulting in death) Due to (or as a consequence of): **Examiner** Alzheimer's Disease 7 years Sequentially list conditions, if any leading to immediate Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events **Hospital or Attending Physician:** The law requires that the death certificate be execut<mark>ed</mark> 24 hours after death. and -tran Due to (or as a consequence of): resulting in death) Last burialphysician at the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) detached for in the past 12 months? Pregnant at time of death the 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension, Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has all director, page 2 1 Yes 2 No 1 Yes 2 🔀 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) Hospital ျှ 2 (No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Director: After (Month, Day, Year) 1 XNatural 5 Pending Investigation Accident completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 12, 2011 ones I - Marken Mi D37678 108W

Registrar DHMH 17 Rev 7/2009

State

James F. Mackin, M.D. 5454 Wisconsin Ave. #675 Chevy Chase, MD 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

SEP 1 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Year} 2011 Florence May Schneider 10:45 P.M September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore 5511 Hutton Avenue 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Days 04/26/1921 213 12 3662 90 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Baltimore 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 5511 Hutton Avenue 21207 12. Was Decedent Ever in U.S. Armed Forces2.
1 ☐ Yes 2 M No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Specify Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Benjamin H. Alder Elizabeth Millenburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Speesler / Daughter 5511 Hutton Avenue Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 09/20/2011 Glen Haven Mem. Park! Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or co shock, or heart failure. List or k inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Breast disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Certificate: To 1 🗋 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No neral Director; A filled in by the fu Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

24 hours a

State Registrar (Check

29b. Signature and title of certifier

SEP 1 6 2011

Duffurs Sin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

470,N

32. Registrar's Signature

1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

2/2/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ September 9:30 A.M Barbara Stansbury Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A 1602 Hazel Street Baltimore g. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Maryland 1 □ M 2 🗓 F Hours 216 38 4101 Month 2 1939 **Director** Usual Residence of Decedent ea orner than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21226 U.S. 1602 Hazel Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔼 No Black White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 7th College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Smith Pearl McKnew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Theresa Burgess / Daughter 1602 Hazel Street Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/16/2011 Baltimore, Maryland Holy Cross Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or co shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or imiun that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No 4 ☐ Pregnam 9 ☐ Unknown s been signed by the s 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performed 1 Yes 2 No 2 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending 1 Yes 2 No Investigation Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined hours & Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 24 (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 11-06762 Hee Sook Choi Soe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Type of I fill life ble				
State of Maryland /	Department o	f Health ar	nd Mental	Hygiene

2011 29665

		1- For State Registrar	Certific	ate of Death		Reg.	No.	2,7000	
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle, Last) Lee Sook Ch	101 S	de la		2. Date of Death Month September		3. Time of Death 1636 hrs	
		4a. Facility Name (if not institution, give street and number 2101 Maryland Avenue	ar)	4b. City, Town, or Baltimore	Location of Death		4c. County of Death	IA	
Funeral Director		055-80-5556 10M 2 12M	Age (In yrs. last bir	thday) If Under 1 Yea Months Day		8. Date of Birth	MM/DD/YYYY) 9. Bir Foreig 2016/961 Co	thplace (State or in untry) Korea	
nd show any	Ì	Usual Residence of Decedent 10a. State 10b. County Four Fax	10c. City, Town	nor Location	2			10d. Inside City Limits 1 Yes 2 No	
death with the Maryland or items 23a or 28a-f show must be notified at once.	ē	10e. Street and Number 4415 Briar Wood	Ct	10f. Zip Code	2003	10g.	Citizen of What Cou		
	Funeral	11. Marital Status 1 Never Married 2 Married Armed Force 1 Yes		13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto		14. Race - Amer White, etc.	Sian Indian, Black,	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	<u> </u>	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) College (1-4)	- 1 - 111	1 Yes 2 No Decedent's Usual Occupa during most of working life			6b. Kind of Business/		
15-0036 illed within 72 Hygiene. d other than	Completed	17, Father's Name (First, Middle, Last)		Clerk	18.Mother's Name	(First, Middle, Ma	Kestau iden Surname)	irant	
:121 Id be fi Aental J	To Be	9a. Informant's Name/Relationship (Type, Print)	19	9b. Mailing Address (Street	et and Number or R	ural Route Numbe	er, City or Town, State	e, Zip Code)	
nore, MD 2 ages I and 2 shou nt of Health and N t: If item 27 is n other traumatic		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from	1	of Disposition (Name of ce tory or other place)	erretery,	Date :	20c. Location - City or	1 1/1	
Baltimore permit. Pages 1 a Department of He Important: If it		1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify: 21. Signature of Funeral Service Light See	Metro	22. Name and Addres	Cool of	10/2011 Me00	Alexand	Ma, VA	
Physician		23a. Part I. Enter the disease, of complications that caus failure. List only one cause on each line.					t, shock, or heart	Approximate Interval Between Onset and Death	
Examiner		or condition resulting in death) Due to (or as a co		<u>Cardiovascul</u>	ar Diseas	se			
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
760, cate be executed physician and the burial - transit	Medical E	d. X UNPENDED	NDED 23a,27,per me,g921 11-21-11 sm						
Box 68760, e death certificate be ex the attending physician of for use as the burial	sician/	23b. Was decedent pregnant in the past 12 months?	at time of death	Fetal death 3 Other (Specify)	Ectopic pregna	ncy	23d. Date of deliver Month	y Day Year	
P.O. Es that the d	by Phy	Part II. Other significant conditions contributing to de	ath but not resulting	ng in the underlying cause	given in Part I.	_	2 No 3 Pro	the cause of death?	
Division of Vital Records, P.O. Box 68: the Hospital or Attending Physician: The law requires that the death certifi him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending inpletely filled in by the funeral director, page 2 should be detached for use as	Completed					24a. Was ar autopsy perform	prior to death?	utopsy findings available completion of cause of	
tal Rec	Be Co	25. Was case referred to medical examiner?			ce of Death (Check	only one)			
n of Vit ding Physic After this c funeral dire	리	1 ✓ Yes 2 No label 1 Inp 27. Manner of Death 28a. Date of	Injury 28b.	Outpatient 3 DOA Time of Injury 28c. Injury	Other Nursin		esidence 6 🗹 Otherwinjury occurred	er: Scene	
/iSion r Attendin ter death. irector: A n by the fu	Certification:	Natural 5 Pending 2 Accident Investigation		farm, street, factory, office	Yes 2 No	28f. Location (Stror Town, Sta		ural Route Number, City	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	- 1	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of	f my knowledge, d	eath occurred at the time, o	date and place, and	due to the cause	(s) and manner as sta	ited.	
To the Hos within 24 h	Medical	one) 2 Medical Examiner: On the basis of and manner stat					nd place, and due to t		
	Σ	29b. Signature and title of certifier	The we	D. 0.C	M.E. OCME		September 8, 2		
Ø		Co. Herrio erra erra erra	of death (Item 23a) Medical Exan	miner 900 W. Balti	more Street, B	altimore, MD	21223		
St	ate	31. Date filed (Month Par Year) 32. Resi	strar s Signature	1.00					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 29666 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dawa1a Month Tuladhar 11:39 PM Sept 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 11102 Woodson Ave. Montgomery Kensington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Year) Director 213-87-4016 83 1 M 2 XF Jan. 1, 1928 Tibet Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11102 Woodson Ave. 20895 Nepal 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Specify: Asian "natural", 3 XWidowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Own Home Homemaker is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ (unknown) (unknown) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 11102 Woodson Ave. Kensington, Maryland 20895 Dolma Tuladhar (daughter) permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of SeptDate 13, cemetery, crematory or other place)
Chesapeake Crematory ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 2011 Beltsville, MD. ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave., Silver Spring, MD M00982 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ disease or condition Medical resulting in death) **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events -tran Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical P.O. Box 68760 the as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Month Year Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) nours after death.

neral Director: After this
y filled in by the funeral di Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, determined City or Town, State) 24 hours a Funeral (Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mayner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 1 only one 29b. Signatur 29d. Date signed (Month, Day, Year) 29c. License number 1

State Registrar ress of person who complete

DHMH 17 Rev 06-2011

ted cause of death (Item 23a) (Type, Print)

1400

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death County of Death Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Min. (Month, Day, Year) 219-40-9473 Director 1 □ M 2X F 10-18-1942 \mathbf{MD} 68 er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 X No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 USA 8610 Bramble Lane, Apt. 103 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian, Was Decedent Ever in U.S. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) 12th Social Security Admin Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked on any injury or other traumatic eve Mary L. Willis Willie H. Totten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8610 Bramble Lane, APt. 103, Randallstown, MD 21133 19a. Informant's Name/Relationship (Type, Print) Derick Tyson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-19-2011 Woodlawn, MD King Memorial Park 22. Name and Address of Facility Whie Funeral Home P.A. of Balto. Co. 21. Signar of Funeral Service Gensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 N 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ☐ Nursing Home 5 ☐ Residence hin 24 hours after death.

the Funeral Director: After this or appletely filled in by the funeral dil Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Aatural work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier nd address of person who completed cause of death (Iter State Registrar

29668 State of Maryland / Department of Health and Mental Hygien ?

Physician /Medical Examiner

Funeral Director

28a-f show injury or other traumatic event, the Medical Examinar must be notified at permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental ygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Extending Derivener.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Box 68760 P.O. Records, Division of Vital this After ours after death.

eral Director: A
filled in by the fu

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month August 27, 2011 11:28 AMM Julius Henry Taylor 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2319 Lyndhurst Avenue Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Feb 15, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Months Days New Jersey 1 X M 2 □ F 97 141-01-1002 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21216 2319 Lyndhurst Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) college physics professor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julia Price Coleman Henry Taylor ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Stone Gate Dr; Baltimore, MD 21208 Dwight Taylor - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation __3 ☐ Removal from State 4 X Donation 5 Other (Specify) 21. Si, n thre of Funeral Service 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 9. TC ocav di Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy Month in the past 12 months? Year 5 Other (specify) 1 □Yes 2 □No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a

To the Funeral C

completely filled

301

Saint Rul

30. Name and address of person who completed cause of death (Item 23a) (Type,

٦٠١

Year

1 homas

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

		Pleas	se Type or Pri									gible.	
	For State Registrar		State of M	arylan		tificate			ivientai m	Reg. N	211		29669
ian/ ical	1. Decedent's Nam	ie (First, Middle, i	Narada A	nn Ta	aylor				2. Date of D Month	eath)ay 1 1, 20	Year 11	3. Time of Death 4:05 P M
iner	4a. Facility Name (ii		give street and number) Stoney Hill Ct.			4b. City, To	wn, or l	Location of Death		4	c. Count	y of Death Anne	Arundel
i	5. Social Security N 095-52-	lumber 6		e (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months D	Year Days	If Under 24 Hrs. Hours Min.	8. Date of B	Birth Day, Year,			place (State or Foreign
Ļ	Usual Residence of	Decedent 10b. County		10c. City, Town or Location					, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				10d. Inside City Limits
Director	MD		ne Arundel	100.00	, 101111 01 201	oution (Odenton	1				1 ☐ Yes 2 🗹 No
al Di	10e. Street and Nur					10f. Zip Co	ode	21113		10g. (Citizen of	What Cou	
To Be Completed by Funeral Director	556 Stone 11. Marital Status 1 Never Marital Status 3 Widowed	ried 2 Marrie	If Yes, Give		l I	Was Deceden f Yes, specify	Cuban	panic Origin? (Sp , Mexican, Puerto	pecify Yes or No o Rican, etc.))- -		ce - Ameri	can Indian,
Completed		15. Decedent' ecify only highest	Year or Dates. s Education grade completed) College (1-4 or 5	(Give I	O NOT use re	lone du tired)	uring most of wor		16b.		Business Ir		
Be C	17. Father's Name (First, Middle, Las				IVU	rsing	Assistant 18. Mother's Nar		e, Maide	n Surnam	Nur	sing
잍			John B. Gr	iggs							a M. I		
		nith Fianc		,	790	0 Benes	ch C	ircle #756 (ie, M	D 210	60	
	4 Donation	Cremation 3 5 Other (Sp.			lace of Dispo emetery, cren Atlantic		r place		Date p 16, 2011	1			own, State
	21. Signature of Fu	neral Service Lic	ensee	1005 B	22	. Name and A Slac 387	Address k Fu	s of Facility neral Home, Columbia P	P.A.	City	MD 21	043	
Examiner	Immediate Cause (Final disease or condition resulting In death) MYOCATO IAC IN FARCTON Due to (or as a consequence of):										Approximate and Interval Between Onset and Death		
d by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 PNo 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yes, outcome of pregnancy 23d. Date of death Month 1 Pregnant at time of death 5 Other (specify) Month 23d. Date of death Month Month 23e. Did tobacco use contribute to Month Month 23e. Did tobacco use contribute to Month Mon									onth tribute to	Day Year		
Completed									_ per	is an topsy formed?		prior to co death?	opsy findings available ompletion of cause of
Be	25. Was case referr examiner? 1 X Yes 2	ed to medical	Hospital:				26. Pla	ce of Death (Che					
cate: To	27. Manner of Deat 1 Natural Accident		28a. Date of inju (Month, Da	ER/Outpatier 28b. Time of injury		Injury work?	4 □ Nursing F at	1	5 Residence 6 Other (Specify) Describe how injury occurred				
Certificate:	3 Suicide 4 Homicide	6 Could no determin	ot be						28f. Location City or To	(Street a	und Numb te)	per or Rura	al Route Number,
Medical	(Check 2	Medical Exa	Physician: To the best of aminer: On the basis of e	xamination	and/or invest	tigation, in my	opinior	, death occurred	at the time, date	and pla	ce, and di	ue to the c	ause(s) and manner state
Σ	only one) 3		Jurse Practioner: To the	pest of my	knowledge, c	29c. Li	cense	time, date and pla number 70 7	ace, and due to	29d. E		Month,	Day, Year)
ate rar	30. Name and addr CARCOS 31. Date filed (Mont	h. Dav. Year)	no completed cause of d	eath (Item	23a) (Type, P	Trint)	. Cį	ZAIN HY	NY, GL	EN	BUR	NIE	Md 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie BaltiHore Washi Anne Medical Center NO TON Nac If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
 Country) 8. Date of Birth **Funeral** 1 ØM 2 □ F (Month, Day, Year) Months Days Hours September of **Director** 220-64-4841 56 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director be notified Maryland Anne Arundel 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a must t 3603 Brooklyn Avenue 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ŏ δ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🔀 No Specify: White "natural", Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Manager Grocery permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Claude В. Unglesbee Theresa Duvall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Nash (sister) 513 Edgewater Road, Pasadena, MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔲 Burial 2 🖾 Cremation 3 🗀 Removal from State Sept. 19 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Funeral Service Cicende 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 23a. Part . Enter the disease, or complications, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 L Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Yes 2 X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 2 No 1 ☐ Inpatient 2 ☑€R/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 \sum Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier Deputy 29d. Date signed (Month Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

ise of death (Item 23a) (Type, Print)

mo

address of person who completed ca

31. Date filed (Month, Day, Year)

JON

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 10:40 A^M 2011 Sept. Michele Edith Vobe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day Yes Aug _ 11, 5. Social Security Number 6. Sex . Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 - M 2 1 F Months Days Hours Min. Year) Germany Yrs 1953 Director 58 219-64-2400 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.

To file 1, 1 is marked other than "natural", or items 23a on ury or other traumatic event, the Medical Examiner must be ury or other traumatic event, the Medical Examiner must be. Funeral United States 20910 8144 Hartford Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Communications Specialist Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Karla Ehleben. Vobe Margot (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne A. Butler / Friend 14012 Manorvale Rd., Rockville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) injury or permit. Page Department Important: It any injury or Chesapeake Crematory 09/15/2011 Beltsville, MD 22 Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Style Dohnne M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END STAGE LIVER DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** GASTROINTESTINAL BLEEDING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last RENAL FAILURE and burial-tran Due to (or as a consequence of) physician Physician/Medical COAGULOPATHY that the death certificate be Box 68760 the guipt IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) atten for u Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No Day Year Month Pregnant at time of death been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page 2 certificate Yes 2 No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2X No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural injury 5 Pending work?
1 Yes 2 No the 1 Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D65953 SEPT. 11, 2011 n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per ADAKU C. ONUKOGU, M.D., 8714 GEORGIA AVE., SILVER SPRING, MD 20910

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) 32. Registrar's Signature

SEP 1 6 2011

iegistrar's Signature

11-06867 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Bernard Venable State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0351 hrs Medical Examiner September 12, 2011 John Bernard Venable 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2918 Poplar Terrace **Baltimore** 5. Social Security Number If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) If Under 1 Year **Funeral** Min. Foreign Country) Hours Months Days 06-05-36 Director VA 227-50-3127 75 1 X M Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 X Yes 2 No MD NA Baltimore Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Importatot: If iten 27 is marked other than "natural", or items 23a or 23a-f abov
jolury or other transmit evect, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2918 Poplar Terrace 21216 USA 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. African If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 1 Yes 2 No specify: specify: American 3 X Widowed 4 Divorced If Yes, Give Year ğ 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) 3rd. Grade NA Supervisor Waste Dept. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk. Be Isabell Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela White-Friend 2918 Poplar Terrace Baltimore, MD. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 09-19-11 Lansdowne, MD Mt. Zion Cem. 4 Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licensee Wylie Funeral Home P.A. Street Baltimore, MD 21217 Street Baltimore, MD 638 N. Gilmor Approximate Interval Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, sician/Medical UNPENDED AMENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? Yes 2 V No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification 1 🗸 Natural 5 Pending 1 Yes 2 No hours after death. To the Fuoeral Director: completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide __ Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 241 Sa 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. September 14, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2011

DHMH 17 Rev 1/2001 OCME 2006

OCME

11-06628 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kenneth Wheeler 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Kenneth Robert Wheeler Medical Examiner September 2, 2011 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Davs unk Director Country) MD 52 01/21/1959 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10b Count 10c. City, Town or Location 10a, State 1 Yes 2 No unk unk Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unk Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code unk unk USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 XNever Married 2 Married White Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify ₫ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9yr Home Improvement Carpenter 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Be Kenneth Wheeler <u>Virqinia Wheeler</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Me Important: If item 27 is ma injury or other traumatic en Eva E. Lawlor sister 509 Brandyvale Way Baltimore MD 21222 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Atlantic Crem 9/15/11 Glen Burnie MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licens ThomasAllenPA 7090 Ridge RD Hanover MD Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Modimal a Mixed Drug (Methadone and Nordiazepam) and Alcohol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Dise to for as a consequence offi cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician a 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Cocaine Use Completed certificate has been 24a. Was an autopsy performed? death? page ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) director. Be examiner? Other Nursing Home 5 Residence 6 Other: this 1 V Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Manner of Death Sep 2, 2011 Natural 1420 hrs 1 Yes 2 ✔ No Pending the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.

1458 hrs

Division of Vital Records, P.O. Box 68760, and Attending Physician: The law requires that the death certificate be executed Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b, Were autopsy findings available prior to completion of cause of 2 No Hospital or Attending Physician: Certification Subject ingested drugs and alcohol within 24 hours after death.

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 1769 E. North Ave (parked outside), Baltimore, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. September 12, 2011 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar ORIGINAL **OCME** DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician/ 2340 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Da g. Birthplace (State or Foreign 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Country) 191-30-6216 1 🗆 M 2 🗹 F Hours **Director** Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Darlington Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21034 USA 4041-29 Conowingo Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African-American If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) n 27 is marked other than "n r 27 is marked other than "n r traumatic event". Elementary/Seconday (0-12) College (1-4 or 5+) Dept. Of Social Services Claims Authorizer 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be fill ment of Health and Mental tant: If item 27 is marked or ၉ Flora Harrison Coleman Lyles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit, Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. 4041-29 Conowingo Road, Darlington, MD 21034 Joseph L. Williams/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 9-16-2011 Metro Crematory 22. Name and Address of Facility lie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Set 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of Examiner umonan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ue to (or as a con a quence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) ed by the a g Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b þ 2 ☐ No 3 ☐ Probably 4 ☑ Unknown s been signal Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 s autopsy death? Yes 2 No 1 🗌 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 V No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 9/13 00495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shin-Dien Mihae 31. Date filed (Month, Day, Year) SEP 16 2011 32. Registrar's Signature State

11-06842 Thomas Willis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0534 hrs Medical Examiner Thomas September 11, 2011 Willis 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** St. Agnes Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Months Davs Hours Min Country) Director 62 MD 1 M 2 F 49 212-82-6121 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in y 1 X Yes 2 No s 23a or 28a-f show : e notified at once. Baltimore NA hours after death with the Maryland 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 21239 U.S.A. 1312 Crofton Road $\bar{\Box}$ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status or items? White, etc. Armed Forces? 1 Never Married 2 Yes 2 X No Specify: Black If Yes, Give Year 1 Yes 2X No specify: 3 Widowed 4 Divorced "natural" ≥ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+ Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 lant of Health and Mental Hygiene.

Taut: If item 27 is marked other than "
or other traumatic event, the Medical Is Baltimore, MD 21215-0036 Construction Co. Construction Worker 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shelby Morris Be Frank Willis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Md 21239 1312 Crofton Road, Shelby Muse-Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9/19/2011 Woodlawn, Memorial Park King 4 Donation 5 Other Specify. 22. Name and Address of Facility
March F/H West permit. ature of Funeral Service Licensee Name Thumpsor 4300 Wabash Ave, Baltimore, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and Hypertensive Cardiovascular Disease Complicated ure. List only one cause on each line. Madical Death by Cocaine Use Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, pt. II, 27 per me g920 10-13-11 vt X UNPENDED g physician a Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 1 Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 2 Sickle Cell Anemia pleted 24a. Was an 24b. Were autopsy findings available this certificate has been 1 director, page 2 should prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 X Natural Yes 2 No 5 Pending Director: d in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Sa and manner stated. 29d. Date signed (Month. Day. Year) 29c. License number 29b. Signature and title of certifier September 12, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner, Carol Allan, MD filed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCMF 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 29676

odger Lee Wall		State of Maryland / Department of Health and Mental Hygiene 1. For State amend #1 Per ME G9 Certificate 30 beath Registrar
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle, Last) Robert Lee Walker 2. Date of Death Month Day Year September 3, 2011 3. Time of Death 0817 hrs
		4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center 4b. City, Town, or Location of Death Wicomico
Funeral Director		5. Social Security Number 177-50-9153 6. Sex 1 Age (In yrs. last birthday) 45 yrs, Months Days Hours Min. 10/20/1965 Foreign PA Country) 9. Birthplace (State or Foreign PA Country)
laryland 8a-f show any at once.	Director	Usual Residence of Decedent 10a. State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral Dire	11. Marrial Status 1 Never Married 2 X Married 2 X Married 2 X Married 2 X Married 2 X Married 2 X Married 2 X Married 2 X Married 2 X Married 2 X Married 2 X Married 2 X Married 2 X Married 3 X Mar
ours after de: atural", or i	ā	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1. Yes 2 X No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
vithin 72 h ene. er than "n Medical E.	Completed	12 College (1-4 or 5+) Landscaping Lawn Care
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Thomas Cecil Walker 18. Mother's Name (First, Middle, Maiden Surname) Bonnie Gail Lambing
MD 21 d 2 should Ith and Mer n 27 is man	೨	19a. Informant's Name/Relationship (Type, Print) Lori Lee Walker Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Irene Ave Salisbury MD 21801
Baltimore, permit. Pages I an Department of Heal Important: If iten injury or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, Acrematory of other place) 4 Donation 5 Other Specify: 20c. Location - City or Town, State 9/5/2011 Glen Burnie MD
Balti permit. Departn Imports injury o	I	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv Thomas Allen PA 7090 Ridge Rd Hanover MD
Physician /Medical	h 14	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
ixaminer		or condition resulting in death) Due to (or as a consequence of):
Х.Д.	Examiner	if any, leading to immediate Due to (or as a consequence of): Cuse. Ener U denying Cause (Disease or injury that initiated
executed ian and ial - transit	Jical Exa	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED
tox 68760, leath certificate be ex attending physician for use as the burial.	ın/Medi	UNPENDED AMENDED 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? AMENDED 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 68760, e death certificate but the attending physical for use as the but	Physician/Mec	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
5, P.O. E ures that the consistence of the detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buril.	Completed	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner? 1 Ves 2 No.
ing Physical After this funeral dir	<u>۲</u>	The split of the s
SiOn (ttending death. ctor: Af	ation	1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Yes 2 No Yes 2 Yes 2 No Yes 2 Yes
Divis	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) September 4, 2011
(M)V		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
S	tate	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 10,2011 Physician/ Month Viola Ruth Williams September 7:45P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2137 Buell Drive Fallston Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F Days Months Hours Min 2-4-1931 Maryland Yrs. 218-26-8215 **Director** 80 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Tes 2 No Md. Harford Fallston 10e, Street and Number 10g. Citizen of What Country? ò 10f. Zip Code d Mental Hygiene. marked other than "natural", or items 23a or matic event, the Medical Examiner must be I Funeral 2137 Buell Drive 21047 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White Completed 3 Divorced 4 Divorced Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Phlebotomist Lab Corp Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Floyd K. Watson Anna Ruth Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merritt Williams Fallston. <u> 2137 Buell Drive</u> Md. 21047 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐XX emation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 9-14-2011 Glen Burnie, Md. Schimunek FuneralHome 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ adenocarcenoma disease or condition metastahi Medical resulting in death) Due to (or as a consequence of) 3 month Examiner ovarian or if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be at thin 24 hours after death.
 the Funeral Director: After this certificate has been signed by the attending physicis impleed filled in by the funeral director, page 2 should be detached for use as the burniples. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 5 Other (specify) 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 9-13-2011 D45530

Registrar DHMH 17 Rev 7/2009

State

upperchesapeako drive, ND-2014

maela

510 eqistrar's Signa ure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WASALLAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. N. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ Ja ZIENTEK SEPTEMBER 12 11:25 /1901 HENRY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE HARBOR HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) Sex. 1 X M 2 □ F **Funeral** Months Hours 02/17/1959 220 70 1506 52 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Anne Arundel Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö Funeral 23a Page 1 and 2 should be filed within 72 hours after death with U.S. 21225 401 Holy Cross Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 5 1 X Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify: "natural" Completed 3 Divorced 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Self employed 12th Handyman Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary G. Neff Henry John Zientek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Josie Colison / sister 401 Holy Cross Road Baltimore, Maryland 21225 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 09/15/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Holy Cross Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signal of Funeral Service Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ea disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami -transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, To Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injurv 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one) nd title 29d. Date signed (Month, Day, Year) 29b. Signature certifi 29c. License number RES MD SEPTEMBER 12

Registrar

DHMH 17 Rev 7/2009

State

HOSPITAL

21225

BALTIMORG

STREET

S. HANOVER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARBOR

32. Registrar's Signature

APOORVA

MOHIT

SEP 1 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month EKISHA BRIGGS 26 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** TAKOMA PARK MENIGOMERY JASHTING TON ADVENTIT HOSPITAT Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Tryfyldad and Tobago Months Hours Min. 129054 4982 28 none Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County be filed within 72 hours after death with the Maryland Examiner must be notified at Director Takoma Park 1 🗆 Yes 2 🔁 No Md Montgomery 10f. Zip Code 20912 7401 New Hampshire Ave. Apt710 10g. Citizen of What Country? ò Funeral items 23a St. Vincent Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Specify: Black ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) University Student Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Edmond Thomas Hazel Ann Briggs permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke amy lijury or other traumatic. any lijury or other traumatic. traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip (1907) 12 Mother 19a. Informant's Name/Relationship (Type, Print) Hazel Ann Briggs Aaron/ 7401 New Hampshire Ave. Apt. 710 Takoma Park, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place St.Joseph Cem. 1 🔀 Burial 2 🗆 Cremation 3 🖾 Removal from State 9/10/2011 Stubbs, St. Vincent 4 Donation 5 Other (Specify) P4NEDPADSREWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ME TASTATIC CASTRIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to or as a consuluence of cause. Enter Underlying ie attending physician and ad for use as the burial- ta it. To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-training. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 18006905 ud Augus? 26 1# 2011

Registrar

State

BERNICE

31. Date filed (Month, Day, Year)

SEP

7600

CARROLL AVENUE, TAKOMA PARKIMO

209121

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MINERY

01 2011

MOUD,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla	-	artment o <i>tificate o</i>		Mental Hy	giene Reg. N2 0	11	29680
ı	Physicia	ın/	1. Decedent's Name (First, Middle, Last) GEORGE ROBERT	REACIEV				2. Date of De Month	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give str			,	n, or Location of Deat	h Hug		2011 ty of Death	
	/ 		Surburban Hos 5. Social Security Number 6. Sex	<u> </u>	I hi-t	Be If Under 1 Ye	thesda ear I If Under 24 Hrs	O Date of Bi		gome	
	Funeral Director		578-42-4873 ^{1/2}	M 2 □ F 7. Age (in yrs.	. last birthday) Yrs.	Months Da			¥932	Gour	place (State or Foreign htry) DC
	and show at	ě	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loc	cation					10d. Inside City Limits
	Maryla 28a-f	irect	DC	Wa	shingt						1 X Yes 2 No
	with the 23a or ist be r	Funeral Director	10e. Street and Number 5112 MacArthur	Boulevard.	#202.N	10f. Zip Cod	20016		10g. Citizen o	f What Cou USA	intry?
ဖွ	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	by Fun		2. Was Decedent Ever in L Armed Forces?	J.S. 13. V	Vas Decedent of Yes, specify C	of Hispanic Origin? (Sauban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	ВІ	ace - Ameri ack, White,	etc.
Maryland 21215-0036	atural"	Completed	3 Widowed 4 Divorced 15. Decedent's Educ	If Yes, Give Year or Dates 953 —		Yes 2 X			16b. Kind of	fy:Whi	
212	nin 72 h ne. fhan "n e Medi	dmo	(Specify only highest grade Elementary/Seconday (0-12)		(Give k	ind of work do O NOT use retir	ne`during most of wo 'ed)		1		Industry
d 21	ed with Hygier other t	Be C	1 2 t h 17. Father's Name (First, Middle, Last)		Tere	phone	Technic	me (First, Middle			Industry
ylan	ld be fil Mental arked atic ev	၉	Russel C. Beasle	е у			Ruby D				_
Mar	2 shoulth and the strain traum.		19a. Informant's Name/Relationship (Type, Elizabeth Malia,				eetand NumberorRe rsity Bl				
Baltimore,	of Heal		20a. Method of Disposition 1 □ Burial 2 【X Cremation 3 □ Re	20b	. Place of Dispos	sition (Name of		Date	20c. Location	n - City or T	own, State
<u>H</u>	artment ortant: injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Ri			Crem 09-	01-201	Kive	rdal	e, MD 20746
Ba	Depart Imperany any	35	pen E/s	end				111 PA	Ave.,	Suit	land, MD
			23a. Part J. Enter the disease, or complicion shock, or heart failure. List only one of Immediate Cause (Final		ath. Do not ente	r the mode of	dying, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Ph, sician/ Medical		disease or condition resulting in death)	Hypercalce Que to (or as a conse	quence of):						110
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Lung cane							
	uted nd ransit	Examiner	Cause (Disease or iinjury that initiated events								
	certificate be executed nding physician and use as the burial-transit	edical E	resulting in death) Last	Due to (or as a conse	quence of):						
8760	tificate or physical occurs.	Medi	IF FEMALE:								
89 xo		-	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	 If yes, outcome of pregretary Live Birth 2 ☐ Fe Pregnant at time o 	etal death 3	Ectopic pregr Other (specif)				Date of delivery	very Day Year
O. Box	The law requires that the death rate has been signed by the atte page 2 should be detached for the state of t	Physi	g 🗌 Unknown	9 Unknown	and the state of t		a since in Don't				
s, P.O	ires that is signed to be do	d by	Part II. Other significant conditions control Hypernatremia	ibuting to death out not h	esalting in the d	nderlying caus	e given in Fait i.	111			the cause of death?
Sord	has beer ge 2 shou	Completed by	Hypernatremia Dementia					24a. Was	s an 24t		opsy findings available ompletion of cause of
Ř	sician: The law certificate has be irector, page 2 s		Chronic Pancreat 25. Was case referred to medical	itis				t ☐ Yes	ormed? 2 ANo	death? 1 Yes	2 🗆 No
Vita	hysician: nis certifical director,	To Be	examiner?	spital: 1 Z Inpatient 2	RR/Outpatien		6. Place of Death (Che Other:	eck only one) Home 5 ☐ Res	idence 6 \square 0	ther (Specif	fv)
Division of Vital Records,	ttending Physdeath. tor: After this the funeral di	te:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. I	njury at vork?	T	how injury occu		<i>//</i>
DIVISI	or All after Direction by	al Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		et, factory, offi	ce		(Street and Nun wn, State)	nber or Rura	al Route Number,
	To the Hospital within 24 hours to the Funeral completed filled	Medical	(Check 2 Medical Examiner	an: To the best of my kno : On the basis of examination Practioner: To the best of	ion and/or invest	igation, in my o	pinion, death occurred	at the time, date	and place, and	due to the c	ause(s) and manner stated.
_	within To the comple	<	29b. Signature and title of certifier	>		29c. Lic	ense number		29d. Date sign	ned (Month,	Day, Year)
P	1 0		30. Name and address of person who dom	MD pleted cause of death (Ite	em 23a) (Tvne. P		- D00532		aug 27		
_	× 0		ELIZABETH KANG -	SUBURBAN	HOSPIT	16-8	600 Old 6	congetow	on Rd , i	Bethe	sda MD
	Stat Registra		SEP 0 2 2011	32. Registry 's Sign	arks						

11-06566 Clarence Edwin By	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death	2968
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3	3. Time of Death 1850 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. County of Death	3
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthgraft 185-32-2778 1 Months Days Hours Min. APRIL 11 1943 Court	place (State or PHIL PA
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 11m. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No NAVY 1 Yes 2 No NAVY 1 Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th 17. Father's Name (First, Middle, Last) MARTIN LUTHER BYRD 10f. Zip Code 10g. Citizen of What Country 10g. Citizen of What Country 10g. Citizen of What Country 10g. Citizen of What Country 11g. A SHEARED 10g. Citizen of What Country 12th 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc. 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) FI.T.ZA SHEARED	in Indian, Black, CK dustry Lip Code) D 20785 own, State
Physician /Medical	7474 LANDOVER ROAD HYATTSVILLE MARYLA	
D. Box 68760, the death certificate be executed by the attending physician and tohed for use as the burial - transi Physician/Medical Ex	d. X UNPENDED AMENDED 23a,pt.II,27,per me,g920 10-27-11 sm IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown AMENDED 23a,pt.II,27,per me,g920 10-27-11 sm 23d. Date of delivery Month Day 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
Division of Vital Records, P.O. Box 68760 To the Etopital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Fundara Directorath. To the Fundara Director, page 2 should be detached for use as the bused performed or the fundary filled in by the fundary director, page 2 should be detached for use as the busedical Certification: To Be Completed by Physician/Met	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism 23e. Did tobacco use contribute to the 1 Yes 2 No 3 Probab 24a. Was an autopsy performed? 1 Yes 2 No 1 Probab 25. Was case referred to medical examiner? 1 Yes 2 No 1 Probab 26. Place of Death (Check only one) 27. Manner of Death 1 Nursing Home 5 Residence 6 Other: So 1 Probab 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 29a. Certifier (Check only one) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, 29c. License number) 29d. Date signed (Month, 29c. License number) 29d. Date signed (Month, 29c. License number)	oly 4 Unknown Day findings available opletion of cause of 2 No Come Route Number, City

24

State 31. Date filed (Month, Day Year)
Registrar SEP 0 9 2001 DHMH 17 Rev 1/2001 OCME 2006

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

32. Regidrar's Signature

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

OCME

29d. Date signed (Month, Day, Year)

September 1, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene n Amended ite1 - State Registrar#26, perM.E., 8/31/11, BA Certificate of Death WCHD Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 0445 M 8 11 Ralph Herbert Beauchamp Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Peninsula Regional Medical Wicomic Salisburt 8. Date of Birth (Month, Day, Yea Jan 10, If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □XM 2 □ F Months Hours Maryland 87 213-18-5470 Director Jan. Usual Residence of Decedent 23a or 28a-f show ust be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Snow Hill MD lWorcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21863 Examiner must 8344 Third Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 1. Marital Status ed Forces Black, White, etc. 1 Never Married 2 X Married "natural", or þ 1 Yes 2 □ No If Yes, Give 11 Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White "43-45 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic exercises. Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) May Cowger Herbert C. Beauchamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8344 Third St., Snow Hill, MD 21863 Jean H. Beauchamp/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Pocomoke City, MD 8/30/2011 First Bapt. Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Holloway Funeral Home, P.A. ture of Funeral Service Licenses 107 Vine Street, Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final due to Physician/ relitible injunes disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner in tracrania Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and -transit Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should hyponamemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 5 Residence 6 Other (Specify) 2 No 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at

Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Certificate: the Hospital or Attending

Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Snow Hill, MD hone 8344 326 54. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29c. License numbe

0700

ddress of person who completed cause of death (Item 23a) (Type, Print)

8/11/11

H50497

2 No

1 \(\text{Yes}

8/24

Chris Snyber, ao. DME Alan 100 ECENTION St. Jalosh

Fall from Ladder

W 32.841

State Registrar

Medical

☐ Natural Accident

5 Pending

RA15+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 29683 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:48 PM CIMDY BUSCHMAN Sept 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** Days Hours 217-60-283 **Director** /30/1958 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD. Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be must be Funeral 1913 Crouse Road 21050 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black. White, etc ō à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural". Specify: 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Bay Robert Cairnes Dorothy Virginia Thompson SEPTEMBER 10. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21901 19a. Informant's Name/Relationship (Type, Print) Robert S. Buschman 31 (Son) Peppertree Circle North East, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Septe 14. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) arroll 2011 Hampstead, Maryland Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Marvland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) BRAIN CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death CINDY BUSCHMAN Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 😿 No 25. Was case referred to medical 26. Place of Death (Check only one) ဂ္ 1 🗌 Yes 2 X No 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 XI Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar JUNECIA WHITE,

31. Date filed (Month, Day, Year SEP 1 6 2011 CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 201^{Year} Annette Mae Chrisman 6:55 A August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Montgomery Montgomery Village Montgomery Village Health Care Center 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth If Under 1 Year 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) 577-05-7969 1 M 2 XF 94 Months Min. Washington, DC Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Germantown 1 Yes 2 No MD Montgomery 10g. Citizen of What Country? United States 6 10e. Street and Number 10f. Zip Code ıral", or items 23a or Examiner must be ı 20876 Funeral 18929 Abbotsford Circle 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working il Hygiene. life. DO NOT use retired)
File Clerk Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed w Department of Health and Mentai Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Ida Mae Paddon ပ John William Luscombe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4419 East West Highway Bethesda, MD 20814 Marc Boland / Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 08/31/2011 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Ligenses 5130 Wisconsin Ave. NW Washington, DC 20016 Intho 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Failure to Thrive Sequentially list conditions, if any colon cause. Enter Underlying Examine Due to for as a consequence of attending physician and for use as the burial transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Sepsis Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ※ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes ∠-9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced Dementia, Severe Malnutrition 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed? this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 🗌 Yes 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred injury 1X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date_signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

SEP

01

DHMH 17 Rev 7/2009

park

Marichu Theresa A. Matas MD 10110 Molecular Dr. Suite 206 Rockville, MD 20850

(29/48

ini

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene																				
		-	For State			State	of Ma	arylan		•		nt of F <i>te of L</i>		and N	/lental F	-	$2 \mathrm{n}$		29685	
			Registrar 1. Decedent's Name	(First, Middle	, Last)					Cert	inca	ie or E)caiii	_	2. Date of		10:- 0	<u> </u>		
Physic Me	cian dica		REBECC					LAR	KSO	N					aug	ist .	0 =	2011	3. Time of Death	
Exam	nine		4a. Facility Name (if n Doctor 's		_			ita	1	- 1		y, Town, or nham	Location	of Death	O		lc. County	y of Death ce George's		
Funer	al		5. Social Security Nur	mber	6. Sex		7. Age	(In yrs. Ia	ast birth	day)		er 1 Year	If Under	24 Hrs.	8. Date of	Birth		Birthplace (State or Foreign		
Directo	or	- 6	578-54-3 Usual Residence of D			M 2 🔀 I		71	Y	rs.	WIGHTE		110010		10000	0219	139	OH		
yland f shov	10a. State 10b. County 10c. City, Town or Location													10d. Inside City Limits						
r 28a- notifie												1 XYes 2 No								
with the s 23a c		= 1	11910 Hi		Dr	ive						744				US				
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at		≥	11. Marital Status 1 Never Marrie 3 Widowed 4		ried	Armed	ecedent E Forces? es 2 X Give Dates.		S.	lf '	Yes, sp	ecify Cuba	ispanic Or in, Mexica Specify	n, Puerto	ecify Yes or I Rican, etc.)	No-		ican Indian, , etc. Ck		
2 hour "natur		Completed	(Spec	15. Deceder			ed)		16a. [Decede Give kii	ent's Us	ual Occup	ation during mos	t of work	ing	16b.	Kind of Business Industry			
vithin 7 vithin 7 vithin 7 vithin 7 vithin 7 vithin 1 vit		E	Elementary/Secon	nday (0-12)		College	(1-4 or 5	+)				e retired) Prac	ctit	ione	er	DC	Go	vernment		
nd if filed v tal Hyg		10 De	17. Father's Name (Fi		,										e (First, Mide	,	n Surnam	e)		
Aarylan (should be file and Mental I is marked craumatic ever	'		Lynwood 19a. Informant's Nan					-	L	A A . 117		<i>(</i> 2)			Wad			04.4. 77.	0-4-1	
Mar 2 sh Ith ar 27 is trau		1	Russell				ı		1	_					Ct.,	-			VA 22556	
nore, ge 1 and it of Heal if item or other		1	20a. Method of Dispo 1 [X] Burial 2		3 □ Re	moval fro	m State	l c	lace of I	crema	atory or	other place	e)		Date			•	Town, State	
Baltimo permit. Page Department o Important: If any injury or	สมี	1	4 Donation 5	5 Other (S	pecify)	,		Ced	lar	-		Cem.	s of Facili		26-20	II S	uit.	Land	, MD 20746	
Dep Dep A	Olo		de	ul/	5/	in	2	1	1						11 P	A Av	e.,	Suit	land, MD	
Physician Medica Examine	al		23a. Part 1. Inter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)	failure. List o inal		cause on	each line	2:2	Z						or respirator		e		Approximate Interval Between Onset and Death	
ate be executed by sician and the burial-transit	- Company	i I	Sequentially list conditions and a classification of the classific	ying njury	c.	Otet	o (or as a	roi segu	ier oe of	r								- 1		
DIVISION OF VITAL RECORDS, P.O. BOX 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the b.	Obusioisial Modic	II yalcıdırı iyin	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 X 9 ☐ Unknown	onths?	230	1 🔲 Liv	egnant at	2 🗌 Feta	l death		Ectopic Other (s	pregnanc	y					ate of deli	very Day Year	
dS, P.O. quires that the en signed by ould be detacl	Ž	2	Part II. Other signific	ant condition	Sta.	ibuting to		ut not res			, ,	6	ren in Part	I.			20		the cause of death?	
HECOTOS, The law requires icate has been sign, page 2 should b	Completed		25. Was case referred												1 □ Y	utopsy erformed?	- 1	prior to o death?	opsy findings available ompletion of cause of	
VITAI nysician: nis certific director,	F B	1	examiner?		Hos	spital:	Inpatie	ent 2 🗆	ER/Outr	patient	3 🗆 [100	er:		k only one) ome 5 \square R	esidence	6 □ Oth	er (Speci	fv)	
ing Ph treet the			27. Manner of Death	5 Pending	a	28a. Da	te of injur	у	28b. Tir			28c. Injury w <u>or</u> k	at ?		28d. Descril					
DIVISION ial or Attendir s after death. al Director; Af	Cortificato		2 Accident 3 Suicide 4 Homicide	Investig 6 Could r determi	ation not be		ce of Injui			n, st re e	M et, facto		Yes 2	No No		n (Street a Town, Sta		er or Run	al Route Number,	
the Hospita hin 24 hours the Funeral	Modical		(Check 2 L only one) 3 L	Certifying	xaminer	: On the b	asis of ex	amination	and/or i	investig	ation, ir	my opinic	n, death o	ccurred a	t the time, da	te and pla	ce, and du	e to the c	ause(s) and manner state	
With Co.		1	29b. Signature and tit	tle of certifier	Amlo	110	. ~~	3				c. License	s number	30	1	29d.	ate signe	4	Day, Year)	
5		+	30. Name and addres	ss of person v	vho com	pleted ca	use of de	ath (Item		-	n+)					,	100	·-		
St	tate	;	31. Date filed (Month, SEP 0		1	_	Registra				9	118 6	rood	Luck	C Rd.	Lanl	nam,	W.	20706	
Regis	trar		2FL 0 3	ZZUII	Ch	re un	/	A	ave											

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 29686 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Agnes 23, 2011 S. 10:40 AM Dixon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 945 Galesville Road Galesville Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) MD 1 - M 2 X F Days Hours 06/05/1904 Director 214-03-5159 Yrs. 107 Usual Residence of Decedent show 10a. State the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MDAnne Arundel Galesville 1 ☐ Yes 💹 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 945 Galesville RD. USA 20765 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 0 Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White "natural", Specify Completed X Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 nd Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Postmaster USPS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Smith Mary B. Nutwell and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .02 Page 1 and 2 s ment of Health 27 Dotty Chaney Daughter 5682 Greenock Rd. Lothian, MD 20711 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Quaker Burial Ground 8/26/2011 Galesville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. . Signature of Funeral Service Licenses 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Intracianis Hemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed andtran resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 'No for Pregnant at time of death Month Day Year ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown s peen si should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autonsy page performe certificate 1 ☐ Yes 2 😿 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No Other: မ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural injury 5 Pending work? death. Accident Investigation 20 /11 2 2 No Fall down Stairs the 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be þ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 45 Galesville Rend, Galesville, MO filled in Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 the only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

OWENSU

an

31. Date filed (Month. Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

08

24/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 28, 2011 Physician/ 10:45 G. label . eiden Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Olney Montgomery General Hospital g. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthpi-Country) PA **Funeral** Sept. I4, Min. 1 ☐ M 2🛣 F 90 Director 174-18-1425 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 ☐ Yes 2 🖺 No Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20902 2705 Munson Street 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces þ 1 Never Married 2 Married Yes 2 No Specify:White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FBT Administrative Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ρ Gertrude Regina Wentz John Pious Leiden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Spring Road, Burtonsville, MD 20866 Sandra Lee Stone/Daughter 4609 Sandy 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Sept. 2011 1X Burial 2 Cremation 3 Removal from State Silver Spring, MD 4 Donation 5 Other (Specify) Francing Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sician/ KespiraToru disease or condition Medical resulting in death) Due to (or as a conseq Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a cons Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed maocardia and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical disease Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death 4 | Pregnant | 9 | Unknown been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural injury work' 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier **B**ompleted 3 🗆 only one) 29b. Signature and title of certifier 54996 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bichhuong 18101 Vrive 'in h

State

Registrar

31. Date filed (Month; Qay,

01

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08 0 1 20 - 20 1 1 HELEN ANNE ST. DENIS 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Malta House Hyattsville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) MA Hours 1 🗆 M 2 💢 F 02-05-1924 **Director** 019-16-1913 87 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amortant: If item 27 is marked outher than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Xyes 2 No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4916 LaSalle Road, 20782 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Professor Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilfred St. Denis Catherine Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $8016\ Holly\ Ave.,\ Waldorf,\ Maryland\ 20746$ James Hyfantis/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 KCremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Pk Crem 08-25-201 Riverdale, MD 20746 21. Signature of Funeral Service Licensee 22. Name and Address of Facility TISha Cedar Hill FH,4111 PA Ave., Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Hospital: Other: ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 08-24-2011 70/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20774 9200 Basil Ct., Suite 200, Largo, Zama, MD31. Date filed (Month, State 2 Registrar

Please Type or Print in Black Indelible Into Fraging All Copies Are Legible.
Amend 29d per med cert/DVR C9Fpsy/26/1/Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene REPLACEMENT 2011-29689 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** A^{M} 2011 80 3:05 Irene D. Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Mitchellville 2512 Red Cedar Drive If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🕱 F 03/15/1926 DC Director 577-34-5099 85 Usual Residence of Decedent with the Maryland 10d. Inside City Limits r 28a-f show 10a. State 10b. County 10c. City, Town or Location 1x Yes 2 No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 39 P Street, Southeast Apt.#10 20024 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. r then "naturel", or items the Medical Exempler on 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ρ 3 ₩ Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed vegating to fleat be partment of Health and Mental Hygies Important: if Item 27 is marked other the eny injury or other traumatic event, the space. 12th Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marjorie Williams Robert Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Ann Anderson/ Daughter 6305 Hard Bargain Circle, Indian Head, MD 20640 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1

Burial 2 □ Cremation 3 □ Removal from State 09/02/2011 Triangle, VA 4 ☐ Donation 5 ☐ Other (Speci Quantico Cemetery 22. Name and Address of Facility Pope Funeral Homes, P.a. 21. Signature of Funeral Service Li Pahr. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. 23a. Party. Enter the disease 5538 Marlboro Pike, Forestville, MD 20746 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Artery Occlusion /Medical Due to (or as a consequence of): Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown should I Atrial Fibrillation Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s Type 2 Diabetes Mellitus certificate 2 No 1 ☐ Yes 2 🙀 No : After this certifical funeral director, i To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify House aughter Hospital: 1 ☐ Yes 2 🛣 No 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 SNatural 5 Pending r death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deal To the Funerel Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Warto a dehined Trom September 19, 2011 D26331 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marta A. Schne.

31. Date filed (Month, Day, Year)
SEP 2 8 2011 5401 Macarthur Blvd, Northwest, Washington, DC 20016 M.D Schneider, Registrar's Signature State backer Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOSEPH WESLEY DOUGHERTY, III 1452M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Regional Medical center Salisburu WICOMICO Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Sex 1 X M 2 □ F Hours 1/1 on 1, 4 av 1 946 DELAWARE 222-30-1523 64 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 X No DELAWARE SUSSEX DAGSBORO 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 208 WOODLAND COURT 19939 US 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō Completed by 1 Yes 2 WHITE 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 X Divorced Year or Dates event, the Medical 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) RESEARCH TECHNICIAN CHEMICAL PLANT and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev JOSEPH W. DOUGHERTY, JR. REBA M. KURATLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 WOODLAND CT, DAGSBORO, DE. 19939 PATRICIA WARD/PARTNER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Semation 3 Removal from State MARINER'S BÉTHEL CEM 9-2-2011 OCEAN VIEW, DELAWARE the (Specify) 4 Donation 21. Sigr MELSON FUNER AL ITYSERVICES, LTD 38040 MUDDY NECK RD, OCÉAN VIEW, DE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SUPSIS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir that the death certificate be executed attending physician and for use as the burial-transil resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Waldenstrum: Mucru globalmemia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: Natural Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie

BH 3

21215-0036

Baltimore, Maryland

Box 68760

P.O.

Records,

of Vital

Division

State Registrar

trar AUG 3 1 201

Delmarra Herr FUL 22. Begistrar's Signature Arman A. Janes

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Silybury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 29 ay 2011 Year Physician/ 2155 \mathbf{P} M Jesse Edwards Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly 9. Birthplace (State or Foreign Country) Washington, DC If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year Jan. 17, 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** 1 X M 2 - F Months Days Hours 936 Director 577-72-1506 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No Landover Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Funeral items 23a 20785 United States 301 Willow Hill Place Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Africian Armed Forces?

1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examino once. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Government Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loretta Stockett 0 Jesse Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20743 6618 Ronald Rd. # 102 Capital Heights, Md. Faith Townes - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Maryland Veterans Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 Washington, DC4001 Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or heart failure. List only one cause on each line. proximate et and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy, performé 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Derth 28b. Time of 28c. Injury at work? 1 \quad Yes 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No Acident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Weddical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

CR

State Registrar 30. Name

31. Date filed (Month

SEP 0

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 0250M **Physician** september 3 20 Vernon A. Eddington /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner (Q) KIVERSIDE Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 11X M 2 T F March 27, 1921 Pennsylvania 216-16-6060 90 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 28a-f show 1 X Yes 2 □ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh amy injury or other traumatic event, the <u>Medical Examiner must be notified onee.</u> Director Havre de Grace Harford MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 4141 U-Way 21078 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW I I 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Logistics Analyst Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ray Ora Weckerly Leon Campbell Eddington ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date Maryland 21078 Dorothy A. Eddington (Daughter) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gardens: 09/07/2011 Aberdeen, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. Signature of Funeral Service Licenses MD 21078 123 S. Washington St., Havre de Grace. Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. 28a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Metastatic ul Physician ichu /Medical Due to (or as a consequence of): **Examiner** anomia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by cate has been signed page 2 should be a 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate Yes After this certification funeral director, p Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 2 No Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 🗍 Inpatient 1 ☐ Yes 28d. Describe how injury occurred 28b. Time of 27. Mapmer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 2 🗌 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3 : 847 40h

State Registrar

DHMH 17 Rev 1/2001

VEY NO

ana

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Month, Day,

6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 29693 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29°, 201°1° 7:22 August Patricia Farkas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Howard Columbia Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 M 2 XF Days Months Hours 01/22/1940 280-34-9024 Ohio 71 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Deale 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20751 USA 6111 Drum Point Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forc Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Toledo Public Schools Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Alfonse Olszewski Agnes Lammers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6111 Drum Point Rd. Deale, MD 20751 William Farkas (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State 8/29/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) tlantic Crematory Signatore of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral HomeP.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death 4 YEARS 3d. Date of delivery Month se contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

29d. Date signed (Month, Day, Year)

COUMBIA, MD 21044

Pnysician Medical **Examiner**

Physician/

Medical

Examiner

Funeral

Director

28a-f shov

Director

Funeral

þ

Completed

Be

2

MD

Department of Health and Mental Hygiene. Important, if items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic avent, the Medical Examiner must be notified at any injury or other traumatic avent, the Medical Examiner must be notified at any injury or other traumatic avent.

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Medica

	lä l
	/Medical
	Physician
	leted by
	Be Comp
	Certificate: To Be Completed by Physician/Medical Exa
	ပီ

29b. Signature and title of ce

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAN 1 EUE DOBERMAN, MD 6336

32. Registrar's Signature

DANIEUE DOBERMAN, MD

AUG 3 0 2011

shock, or heart failure. List o Immediate Cause (Final disease or condition	y one cause on each lineaSMALLBOWEL6	AR CTOURTIN	/	Interval Between Onset and Death WELLS
resulting in death)	a. Due to (or as a consequence of):	200/ Kuchu		WELLX
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. OVARIAN CANCE Due to (or as a consequence of).	R		14 HEARS
that initiated events resulting in death) Last	C. Due to (or as a consequence of):			
IF FEMALE:	23c. If yes, outcome of pregnancy		22	3d. Date of delivery
in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic 4 ☐ Pregnant at time of death 5 ☐ Other (sg. 9 ☐ Unknown			Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
DIABETES			1 🗆 Yes 2 🗴	No 3 ☐ Probably 4 ☐ Unknown
HYPERTENS.			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		26. Place of Death (Check only	one)	
1 ☐ Yes 2 🗶 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D	Other: 4 Nursing Home	5 Residence 6	Other (Specify) HOSPICE
27. Manner of Death 1 X Natural 5 Pendin 2 Accident Investig	(<i>Month, Day, Year)</i> injury tion M		Describe how injury of	
3 Suicide 6 Could 4 Homicide determ			Location (Street and City or Town, State)	Number or Rural Route Number,
	hysician: To the best of my knowledge, death occured at aminer: On the basis of examination and/or investigation, in			

State

Registrar

ack

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

CEDAR LANE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29694 State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 29, 201 Î^{ea} 5:20 P M John Forrest Floberg 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 11219 WIllowbrook Drive Potomac Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Days Hours 1 **₹** M 2 □ F 1072871915 Illinois 055-16-4847 95 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Potomac 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11219 Willowbrook Drive 20854 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.

Armed Forces?

1 Very Yes 2 No 1941.

If Aes, Give 1946 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 1946 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Emily Jurney Frederick Oscar Floberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11219 Willowbrook Drive Potomac, MD 20854 Cecelia Elizabeth Floberg/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖺 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 109/08/2011 Des Plaines, Illinois 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery 22. Name and Address of Facility Joseph Gawler's Sons Inc. Signature of Funeral 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failured, list only one cause on each line Approximate

Physician/ Medical Examiner

permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur. any injury or other traumatic event, the Medical gonce.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/

Medical

10a. State

MD

Director

Completed by Funeral

Be

ပ

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician that completed filled in by the funeral director, page 2 should be detached for use as the burial- rapid.

Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition Inanition									
resulting in death)	Due to (or as a consequence of): Dementia, Alzheimer	Years							
if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence of):								
that initiated events resulting in death) Last	Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		topic pregnancy ner (specify)		23d. Date of delivery Month Day Year					
Part II. Other significant conditions co	ntributing to death but not resulting in the under	lying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown					
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
25. Was case referred to medical		26. Place of Death (Check	k only one)						
examiner? 1 ☐ Yes 2 🔀No	Hospital: 1	☐ DOA Other: 4 ☐ Nursing Ho	me 5 🙀 Residence	6 ☐ Other (Specify)					
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	28d. Describe how inju	rry occurred					
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)					
(Check 2 Medical Examin	ician: To the best of my knowledge, death occur ner: On the basis of examination and/or investigation e Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at	the time, date and place	e, and due to the cause(s) and manner stated					
29b. Signature and title of contifier		29c. License number	29d. D	ate signed (Month, Day, Year)					

DC: MD33474

August 30, 2011

Registrar DHMH 17 Rev 7/2009

C

State

David M. Hansen MD 3301 New Mexico Avenue NW #348 Washington, DC 20016

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:50 AM MILDRED FLOYD Augus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's County Hosp. Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 0 7^{Month} 2^{Day,} 1^{regr)} 2 4 1 □ M 2 😿 F 87 247-24-9568 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 ☐ No MDPrince George's Capitol Heights 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 20740 1102 Booker Drive 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 🗓 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🕅 No Specify. Specify: 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Worker Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumation. ည Nellie V. Orie Peter White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1102 Booker Dr.,Capitol Heights, MD 20740 Frank Lloyd, Jr./son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cemetery crematory or other place)
Lincoln Mem. Cem. 1 X Burial 2 Cremation 3 Removal from State 09-01-201 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 20746 22. Name and Address of Facility 21. Signature of Juneral Service Licensee Cedar Hill FH,4111 PA Ave.,Suitland, 231. Part 1. Enter the disease, or complications that caused shock of heart failure. List only one cause on each line ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death mmediate Cause (Final FATAL Ph, sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in doubt), act Examine Due to (or set a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an uns certificate has b il director, page 2 sh performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 X No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my know Medical Examines. On the basis of examination /ge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner On the basis of exam Certifying Nurse Practioner: To the bea my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL SATTARIAN MD 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

ı	For State Registrar				d / Dep		Health and	All Copie Mental Hy	giene	011	29696	
ian/ dical iner	1. Decedent's Name (Ray F. 4a. Facility Name (if no	Gain	es Jr.			4b. City, Town,	or Location of Dea	2. Date of De Month August	ath Day	2011 ounty of Death	3. Time of Death 2:27 A M	
al	Anne Arun	del Medi	cal Cente		st birthday)	Annapo]	is	s. 8. Date of Bir	An An	ne Aru	nde1 hplace (State or Foreign	
or	424-20-91 Usual Residence of D		X M 2 🗆 F	83	Yrs.	Months Days	Hours Mir	017307	°1 [°] 9 [°] 28	Ala	bama	
Director		Ob. County Anne Aru	ndel	10c. City Oden	, Town or La	cation			_	10d. Inside City Limits 1 ☐ Yes 2 🏋 No		
Funeral D	10e. Street and Numb		hard Ct.	#104		10f. Zip Code 21113			10g. Citize	en of What Cou	untry?	
ed by Fur	11. Marital Status 1 ☐ Never Married 3 🂢 Widowed 4		12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.			Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X N	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		Race - Amer Black, White Decify: Whi	e, etc.	
To Be Completed by Funeral Director		15. Decedent's Ed fy only highest gra day (0-12)		5+)	(Give life. D	dent's Usual Occu kind of work done O NOT use retired ICE & Ins	during most of w	orking	16b. Kind	of Business I	ndustry	
To Be	17. Father's Name (Fir	st, Middle, Last) Gaines					1	ame (First, Middle, ret Ruth	Maiden Su	rname)		
	19a. Informant's Nam Brian Gair				1	-		Rural Route Number				
			Removal from State	, 0	emetery, crei	osition (Name of matory or other pla		Date 29/2011		ation - City or Burnie		
100	21. Signature of Fune	ral Service Ocens	90				ess of Facility	Hardesty Gambrill	Funer	al Hom	e P.A.	
dical Examiner	Immediate Cause (Fir disease or condition resulting in death) Sequentiary list condition and the cause in the cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La	nal filtrons, pediate ing jury	Due to (or as d	a conseque	ence of):	tive Po	Umonos	y Dise	ase.		Interval Between Onset and Death	
Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23	d. Date of deli	ivery Day Year	
þ	Part II. Other signification	ant conditions co	ntributing to death	but not res	ulting in the u	underlying cause g	jiven in Part I.	23e. Did 1			the cause of death?	
Completed								24a. Was auto perfo 1 \(\sum \text{ Yes}		prior to death?	topsy findings available completion of cause of	
To Be	25. Was case referred examiner? 1 Yes 2	. h	Hospital:	ient 2 🗆	ER/Outpatie		Place of Death <i>(Cf</i> her: 4 \(\sum \) Nursing	neck only one) Home 5 Resi	dence 6	Other (Speci	ify)	
Certificate:	2 Accident	5 Pending Investigation		ury ay, Year)	28b. Time o injury	woi	ry at rk? ☑ Yes 2 ☐ No	28d. Describe	now injury o	occurred		
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town,									Number or Rur	ral Route Number,	
Medical	(Check 2	Medical Exami	ician: To the best oner: On the basis of e Practioner: To the	examination	and/or inves	tigation, in my opin	ion, death occurre	d at the time, date	and place, a	nd due to the c	cause(s) and manner stated	
	29b. Signature and titl	e of certifier) Zp, mD			29c. Licen:	0517		29d. Date :	signed (Month	n, Day, Year)	
	30. Name and address	s of person who c Step he	ompleted cause of	death (Item	23a) (Type, I	Print) Af	tmc					
tate trar	31. Date filed (Month,	Day, Yedr) AUG 302	32. Registr	ar's Signat	ure A.	back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State 8/30/2011 AACO HEALIH DEPT. CMH 29697 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2006 Month 7 Physician/ 2011 GARGAN FRANCIS Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 9. Birthplace (State or Foreign New Indiana) If Under 1 Year If Under 24 Hrs Date of Birth 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 M 2 D F Months Days Hours 100/15/1932 78 175-24-8162 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Director Centreville Maryland Queen Anne's 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ò USA 23a (21617 Funeral 244 Heritage Way Page 1 and 2 should be filed within 72 hours after death with or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married 1 □XYes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐XNo Specify: "natural", 3 Divorced 4 Divorced Year or Dates. 52-55 th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturer's Representative Furniture Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anne Laflin Thomas Gargan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
244 Heritage Way, Centreville, MD 21617 19a. Informant's Name/Relationship (Type, Print) Lucy Gargan - Wife item 27 or other 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any Injury or otl once. 1 Burial 2x Cremation 3 Removal from State 8/31/2011 Baltimore Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility John M. Taylor 47 Duke of Gloucester St. Armaculs, 44 Heritage Way, Centreville Taylor Funeral Home Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final UPATHIC ULMONARY FIBROSIS Physician/ disease or condition resulting in death) DI Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death ed by the a detached f Unknown sate has been signed by page 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Ta w Name and address of person who completed cause of death (Item 23a) (Type, Print MOYYS DOKENST HIGHWAY

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 7, 9:30 PM Leslie Meade Hanger 2011 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death Ac. County of Death
Prince George's Renaissance Gardens at Riderwood Village Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months 347-14-7366 88 Aug. 9,1923 **Director** Illinois Usual Residence of Decedent show 10a. State 10b. County I Oc. City, Town or Location the Maryland 10d. Inside City Limits Director or 28a-f sh notified a Silver Spring Maryland | Prince George's 1 ☐ Yes 2 🕅 No 10e. Street and Numbe 10g. Citizen of What Country?
United States ò 10f. Zip Code r must be Funeral 3148 Gracefield Road, CL213 20904 items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give 1943–1945 Year or Dates 1943–1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Specify 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Electrical Engineer I.B.M. alth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Murita Meade Leslie Liberty Hanger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Mary S. Hanger -wife 3148 Gracefield Road, CL213 Silver Spring, MD 20904 other 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. Metropolitan Crematory9/8/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service License Donated Vor Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Opset and Death 6 years Immediate Cause (Final Physician/ End Stage Kidney Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular Disease 5 years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examir the attending physician and hed for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Month Day s been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 page performed? Yes 2 No this certificate 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 X No မ 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 9 29d. Date/signed (Month, Day, Year) 126

Registrar

DHMH 17 Rev 7/2009

State

16

Julaine Harding, NP 3110 Gracefield Road Silver Spring, Maryland 20904

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		1	
,	ysici Medi kami	cal	

Division of Vital Records, P.O. Box 68760

			Pleas	e Type or Pri									Legi	ble.		
		For State		State of M	arylan					ınd Me		-	0 1	1	20600	
		Registrar 1. Decedent's Name	/Eiret Middle I	aetl			Certific	ate of D	<i>Death</i>		2. Date of Dea	Reg. No.	<u>U I</u>	1	29699	٦
Physicia		PRESTON S		•							2. Bale of Deal 08/25/2			Year	3. Time of Death 10:05 PM	
Medic Examin				ve street and number)			4b. 0	City, Town, or	Location of		, , , , ,		County of	of Death	1 20,000 =	٦
		Friends 1					Sandy Spring					Montgomery				
Funeral Director		5. Social Security Nu.	580	Sex 7. Ag 1 ☑ M 2 ☐ F 9	e (In yrs. la 2		day) If Ur Mont	hs Days	If Under 2 Hours		8. Date of Birth (Month, Day) 05/05/1	th y, Year) 9. Birl Cor L919 GA			place (State or Foreign htry)	
nd how at	ž	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	v. Town	or Location							1	10d. Inside City Limits	┪
farylar Ba-f s tified	ecto	MD	Montgan	ery	Sil	ær	Spring	9							1X Yes 2 □ No	
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Num	nber				10f	Zip Code				10g. Citi	zen of W	hat Cou	ntry?	٦
h with	nera	3272 Gleneagles Drive				20906						USZ			_	
r deat or iter	by Fu	11. Marital Status1 Never Marri	ied 2 🕅 Marriad	12. Was Decedent	at Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Specify Cuban, Mexican, Puerto R					ify Yes or No- ican, etc.)		- Amerio , White,	can Indian, et <i>c</i> .			
rs afte rral", o		3 Widowed		If Yes, Give Year or Dates.	194		1 □ Y∈	Yes 2 🛛 No Specify:				Specify: B1			ck	
2 hou "natu edical	Completed	(Spe	15. Decedent's cify only highest	Education grade completed)			Give kind of	Jsual Occupa work done o		of working	9		nd of Bu			
ithin 7 ene. r than	Com	Elementary/Seco	onday (0-12)	College (1-4 or	5+)		ife. DO NOT taome :	use retired) Y Cou	ntv Ti	nspec			.gan	-6-	County	
iled w Il Hygi othel rent, 1	Be	17. Father's Name (F	First, Middle, Las	t)		1.017	-	1		-	(First, Middle, I					
d be f Vienta arked atic e	입	Pleasant	Jacksor	1					Matt	ie Gı	rant			_		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na									Route Number					
and 2 Health em 27 ther t		Charleen 20a, Method of Disp		/wife	20h 0						#2C, S				g , MD 20906 own, State)
age 1 ent of l it: If it		1 🔀 Burial 2 l	Cremation 3	Removal from State				(Name of or other plac								
mit. Pa bartme bortan injur		21. Signature	5 Other (Spe		/ Che	1/ce					/2011 <i>w</i> den Fu				МД	۲
Imp any		· A	enge	Differ	nd						t, Rock				0850	
Physician/		shock, or hear Immediate Cause (rt failure/List only Final	mplic tions that cause one cause on each lin	e. /	1			g, such as c	cardiac or	respiratory arm	est,			Approximate Interval Between Onset and Death WEEK	
Medical Examiner		disease or condition resulting in death)	n á	a. Urinar Due to (or as				_LO[1						-	I week	_
	er	Sequentially list co	nditions,	b. — Due to /or se	a consequ	ience of	n.									_
T Insit	Examiner	if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or iinjury														
e)	I Ex	that initiated events resulting in death) I		Due to (or as	a consequ	uence of	f):				-					
ite be hysicii he bu	edica	d											_			
ertifica ding p se as t	/Me	IF FEMALE:		23c. If yes, outcome	of pregna	incv							23d. Date	- of doll		
eath c atten	Physician/M	23b. Was decedent in the past 12 r 1 Yes 2	months?	1 Live Birth 4 Pregnant	2 Feta	al death	3 Ecto		у				Mor		Day Year	
the d	hys	g 🗌 Unknown		9 ∐ Unknown												_
ires that signed d be del	by			accident,				ing cause glv	ven in Part I.						the cause of death?	
v requ s been shoul	Completed	coronary	artery	disease							24a. Was a				opsy findings available	_
The law te has page 2	omo										autop perfor	med?	d	eath?	ompletion of cause of 2 No	
sian: 7 ertifice ctor, p	Be C	25. Was case referre							ace of Death	h (Check o						
Physic this co	မ	1 Yes 2 2				ER/Out	patient 3		4X Nur		ne 5 🗆 Resid				y)	_
ding l th. After funer	cate	1 Natural 2 Accident	5 Pending Investigat	28a. Date of inju (Month, Da			jury M	28c. Injury work			8d. Describe h	ow injury	occurre	d		
Atten er dear ector: by the	Certificate:	3 Suicide 4 Homicide	6 Could no	be 28e. Place of Inj										r or Rura	al Route Number,	_
ital or irs afte al Dir led in				building, et	c. (Specify	() 					City or Tow	n, State)				
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	Medical Exa	nysician: To the best of miner: On the basis of e urse Practioner: To the	examination	n and/or	investigation	n, in my opinio	on, death occ	curred at t	he time, date a	nd place,	and due	to the ca	ause(s) and manner stated	d.
To the with To the		29b, Signature and	title of certifier	Smilas	$\sqrt{}$			29c. License							Day, Year)	
4		30. Name and addre		o completed cause of o	death (Item	1 23a) (T	ype, Print)	D533	6/			08/3	31/20	<u> </u>		_
		Shyamsun		in, MD 980	⊥ Geo	orgi	a Aver	nue, #	117, 5	Silve	er Spri	ng,	MD :	2090	2	_
Stat Registra		31. Date filed (Mont)	P 01 20	11 Registr	ar's Signa	ture	harles	2.								
				-												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30 201 0235 Am Physician/ Lee Jackson nwen Medical Town or Location of Death 4a. Facility Name (if not institution give street and number) 4c. County of Death Examiner toward COUNT Colum Dul alvero Mouno If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F (Month, Day, Year) 03/14/1945 Country) DC Yrs **Director** 577-58-3188 66 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 28a-f Columbia 1X Yes 2 No Md Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 be 23a 8107 Tide Rock Square 21045 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify. Specify: Completed 3 Widowed 4 Divorced **Black** Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Service Administrative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harron Abbott Rosa Mae Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Jackson/Son 6021 Toomey Lane, Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Speq#fy) 09/9/2011 Lincoln Memorial Suitland, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Lice 5538 Marlboro Pike, Forestville, MD 20746 23a, Part 1. En er the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Day Pregnant at time of death ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Yunknown Completed Were autopsy findings available 24a, Was an prior to completion of cause of death? performed' 2 1400 1 TYes Yes 2 🗔 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 filled in by the funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28a. Date of injury 28d, Describe how injury occurred (Month, Day, Year) Natural 5 Pending s after death. 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)
August 30 20 11 29b. Signature and title of certifier 30641

Registrar

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramesh Sabapathi 201-169 Back RWW MCK Road Balfowy May kid

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:38 AM Myra Penina Knight August Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** Prince Regional George's Laurel Hospital aure If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours 1 🗆 M 2 🔀 F Days (Month, Day, Year, NC Director 241-76-1803 03/10/1945 Usual Residence of Decedent Fshow 10d. Inside City Limits . Page 1 and 2 should be filed within 72 hours after death with the Maryland frnent of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shov jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Upper Marlboro MD Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 20774 AZU 10726 Castleton Turn 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Technical Data Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Bland Venice E. Knight, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10726 Castleton Turn, Upper Marlboro, MD 20774 Nashieka Knight / daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Knight Family Cemetery 9/02/2011 Ernul, NC 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service Linen 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Ver 1 year 23a. Part 1. Enter the disease, or Immediate Cause (Final of the Oesophagus Ph_ysician/ Cancer over disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law equires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) n signed by the a ld be detached for 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Encephalopathy 1 Tes 2 No 3 Probably 4 Unknown pege 2 should k een 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death?
1 🗌 Yes 2 🗙 No Yes 2 nin 24 hours after death.

the Funeral Director: After this certific
ripleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I complet з 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 25, 2011 August

State Registrar yed A.

31. Date filed (Month, Day, Year) SEP 0 2 2011

Sadia

14333 Laurel Bowie Rd., St. 208

MD 20708

Laurel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Richard Henry Kagle 26/1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMIOD 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** April Days 20 P 1 🖾 M 2 🗆 F 577-40-8825 79 Washington, DC Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director Lanham 1 X Yes 2 No 28a-f Prince George's Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 Funeral with 23a 20706 USA 9020 2nd Street items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. or 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Completed by Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Glazer traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Ralph Kagle Ruth Bayliss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 9020 2nd Street, Lanham, MD 20706 E. Diane Kagle / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 9/6/2011 Brentwood, Maryland Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 has after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No I ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year,

DHMH 17 Rev 7/2009

State Registrar EASTERN STOKE DK, SALISBURY

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Sep 4. 1:10 AM Sandra Kav Kasecamp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Western Maryland Hospital Center Hagerstown Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) MD 1 M 2 X Hours Min. Month, E **Director** <u>215-68-6914</u> 56 Usual Residence of Decedent 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director LaVale MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 12410 Butler Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae Dicken Joseph Logsdon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 12410 Butler Drive LaVale 19a. Informant's Name/Relationship (Type, Print) 12410 Butler Drive MD 21502 Shama Willetts daughte 20b. Place of Disposition (Name of cemetery, crematory or other place Sunset Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/7/2011 MD Cumberland Donation 5 Oher (Specify) f Funeral Ser 21 ignature e Licensee 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the dise or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part # Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 100 Month Day Year Pregnant at time of death the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ ros desm Division of Vital Records, 1 Yes 2 No 3 Probably 4 Completed 3 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral 1 Natural 5 Pending 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practipner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 027891 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1200 ERACCISC ANDRADE

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2011 Physician/ Month August 26, 3:40 AM Edward Lloyd Joseph Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 8103 Legation Road New Carrollton 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number . Age (In yrs. last birthday) **Funeral** April 10, Days Hours Months Maryland 1931 Director 213-24-3743 80 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location Director 1 X Yes 2 No New Carrollton Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Funeral United States 20784 8103 Legation Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 African 1 ☐ Yes 2 A No Specify. Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Chief Warrant Officer 4 Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be fill iment of Health and Mental tant: If item 27 is marked o မ Agnes B. Gaskins Bernard Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 New Carrollton, Maryland 8103 Legation Road Alice Lloyd - Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery October Arlington, Virginia 2011 22. Name and Address of Facility Stewart Funeral Home, Inc. Signal of Florral Service Licensee 4 pm 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, ician/ Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 2 🗌 No s been signed by the s should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 has performed' 1 Yes 2 No this certificate Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be examiner? Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 은 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 X Natural 5 Pending n 24 hours after death.

E Funeral Director: After the function by the function of the functin 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of VA/0101245663 August 31, 2011

State Registrar

SEP 0 2 2011

31. Date filed (Month,

Aaron Flanders,

ame and address of person who completed cause of death (Item 23a) (Type, Print)

20307

Washington, DC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Aug. 26, 2011 Physician/ M q00:8 Madrigal Artemia Lorenza Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death
Montgomery **Examiner** Silver Spring Fox Chase Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (8/9/17) 1949 20 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🔀 F 91 Months Days Hours Min. Nicaraqua 217-02-6652 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a, State 10c City Town or Location Silver Spring items 23a or 28a-f sho her must be notified at Director MD Montgomery 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country?
Nicaragua 10e. Street and Number 20910 Funeral 2015 East West Highway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Decede to Thispan, Mexican, Puerto Rican, etc., Nicaraguan Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ 1 X Never Married 2 Married White 1 Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Homemaker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Own Home College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle, Maiden Surname) Carmela Jimenez ည Ramon Madrigal 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 206 Leighton Avenue Silver Spring, Md20901 Leslie Madrigal Lazaro, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Silver Spring, Md Gate of Heaven 8/30/2011 4 \square Donation, 5 \square Other (Specify) PANEL IPADDESS BENALDI FUNERAL SERVICE, P.A. 21. Signatur 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chronic pulmonary disease Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence of: cause. Enter Underlying Anemia Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Atrial fibrillation Certificate: To Be Completed by page 2 director,

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial the Division of Vital Records, P.O. Box 68760 n signed by the at Id be detached fo has this funeral After within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu

death with the Maryland

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23d. Date of delivery Month Day Year								
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown							
	24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ♣ No 1 ☐ Yes 2 ☐ No								
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Other: 4 🗷 Nursing Hor	ne 5 Residence 6 Other (Specify)							
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investiga	(Month, Day, Year) injury work? ion M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred							
3 Suicide 6 Could no 4 Homicide determin		28f. Location (Street and Number or Rural Route Number, City or Town, State)							

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) August 29, 2011 29b. Signature and title of certifier R116833

Nome 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15245 Shady Grove Rd #130 Rockville, Md 20850 Lemoll Johny CRNP

State Registrar

Medical

and manner stated

Assistant Medical Examiner

2. Registrar's Signature

ÓRIGINAL

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Sputhall, MD

31. Date filed (Month, Day, Year)

State

Registrar

29d. Date signed (Month, Day, Year)

September 6, 2011

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

			Please Type or I amend State of	Print in Black In	ndelible In	k. Ensure All C	opies Are	e Legible.					
			For State Of State Of Registrar		tificate of l		ai Hygiene Reg. N	7 11 1	29707				
	Physicia Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Abdul Bari Masood				te of Death onth tember Da	ĭ2, 2011	3. Time of Death 1:47A. M				
	Examir		4a. Facility Name (if not institution, give street and numb Holy Cross Hospital	per)	4b City, Town, o	Spring		Montegonie	ltgomery				
	Funeral Director		5. Social Security 4.399 6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Da Hours Min. Aug	te of Birth ont BD4/999	9. Bird	hplace (State or Foreign				
	f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits				
	the Mary or 28a- e notifie	Direc	Maryland Montgomery 10e. Street and Number	Germantov	10f. Zip Code		10a. Ci	tizen of What Co	1 Yes 2 No				
	ms 23a must b	unera	12914 Creamery Hill Driv		208		Un	ited Sta	ates				
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 🄀 Married 3 ☐ Widowed 4 ☐ Divorced Armed Force 1 ☐ Yes, Give Year or Date	2 L X. No	Vas Decedent of Fif Yes, specify Cuba	lispanic Origin? (Specify Yean, Mexican, Puerto Rican, Specify:	- 1	14. Race - Ame Black, White Specify: Sout					
21215-0036	within 72 horgiene. The than "na the Medic t, the Medic	S Comple	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-2)	(Give I	O NOT use retired)	durina most of workina	- 1	king	Industry				
Maryland	ld be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Husain Abdul Munim 18. Mother's Name (First, Middle, Maiden Surname) Zainab Begum										
	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print) Khurshid Masood -wife	19b. Mailir 12914	g Address (Street 4 Creamer	and Number or Rural Route y Hill Road	Number, City or Germant	Town, State, Zip	cyland 20874				
Baltimore,	Page 1 a ment of H tant: If ite ury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	State Fort Linco	natory or other plac	Date Date 9/12/2011		ocation - City or ntwood,	Town, State Maryland				
Balt	permit Depart Import any inj		21. Signature of Funeral Service Licensee	and B	onald V.	Borgwardt Fuer Mill Road	meral H Beltsvi	lome, PA 11e. Ma	rvland 20705				
	Physician/		23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition	used the death. Do not ente					Approximate Interval Between Onset and Death				
	Medical Examiner	Ĺ	resulting in death) a. Due to (o Sequentially list conditions, b.	r as a consequence of):									
	uted od ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Unique or injury that initiated events c.	r as a consequence of):									
90	te be executed nysician and ne burial-transit			r as a consequence of):									
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physici ated filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	in the past 12 months?		Ectopic pregnand Other (specify)	ру		23d. Date of del Month	ivery Day Year				
, P.O.	ires that the dearings is signed by the aid be detached to		Part II. Other significant conditions contributing to dea	ath but not resulting in the u	nderlying cause gi	ven in Part I. 23			the cause of death?				
of Vital Records,	law require has been si le 2 should	Completed by				24	1 ☐ Yes 2 Ia. Was an autopsy	24b. Were au	topsy findings available completion of cause of				
I Re	sician: The la certificate ha irector, page 2		25. Was case referred to medical		26 0	ace of Death (Check only o	performed? Yes 24 No	death?	2 X No				
Vita	hysician: nis certific I director,	To Be	examiner?	npatient 2 ER/Outpatien	Oth			S Other (Speci	ify)				
on of	al or Attending Ph s after death. I Director: After th d in by the funeral	Certificate:	2 Accident Investigation	f injury 28b. Time of injury injury	28c. Injur work M 1 🗆		escribe how injur	y occurred					
Division	tal or Atterns after de al Directo	al Certii		f Injury - At home, farm, stre g, etc. <i>(Specify)</i>	et, factory, office		cation (Street and y or Town, State,		al Route Number,				
	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best Check only one) 3 Certifying Nurse Plactioner: To	of examination and/or invest	ation, in my opinio	on death occurred at the time	e date and place	and due to the	ause(e) and manner stated				
	To To To To To To To To To To To To To T		29b. Signature and title of pertified MO	Hapitalist	29c. License D712			te signed (Month tember	1, Day, Year) 12, 2011				
	2 AL		30. Name and address of person who completed cause Ahmad Malik, M.D. HCH 150	00 Forest Gle		ilver Spring	, Maryla	and 2091	.0				
	Stat Registra	te ar	SFP 16 2011 Series 32. Reg	gistar's Sight the Kal									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ 201 1:10 AM argaret MIPPS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 **XX** Days 372971948 Country) 215-46-4045 63 DC Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Davidsonville 1 Yes 2XXNo MD Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21035 USA 1111 Double Gate RD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian 11 Marital Status Armed Forces Black White etc. 1 Never Married 2 Married 1 Yes 2XXNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Margaret Levy Arthur Mulloy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1111 Double Gate RD. Davidsonville, MD 21035 Sharon Lynn Hoover Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9/2/2011 Davidsonville, MD 4 Donation 5 km Other (Specify) Entombment Lakemont Memorial Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death iomplications of acute leukemia Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed transit and that initiated events Due to (or as a consequence of): resulting in death) Last use as the burial physician Physician/Medical Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknown detached g Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed 1 Yes 2 No 1 Yes 2 N certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 nours after death.

neral Director; After the filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work?
1 Yes 2 No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) thin 24 hours a the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number P 25581 08, 29, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland, 21201

State Registrar

31. Date filed (Month, Day, Year)

South Greene Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29709 State of Maryland / Department of Health and Mental Hygiene? 1 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0.8 - 30 - 2.011Physician/ 11:23 P.M MATTIE SUE MARTIN PRATT Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Bayridge Health Care Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) 73 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth 6. Sex Country) GA **Funeral** h 7^{Month}5^{Day}1^{Year}38 Hours 1 □ M 2**X**□XF 579-50-5848 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 X Yes 2 No Prince George's MD Glenarden 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 8636 Leslie Avenue 20706 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Yes 2 X No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify:Black 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mail room clerk Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Jessie Lee Martin, Carrie N. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20747 19a. Informant's Name/Relationship (Type, Print) Robbin Pratt/daughter 6027 Surrey Sq. Ln., District Heights, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cem. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-08-2011 Suitland, Maryland 20746 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 118ha Cedar Hill FH,4111 PA Ave., Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause popular line. Immediate Cause (Final husslerola Carchivescular Priysician disease or condition Medical resulting in death) Examiner Securially list no difficus if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.

Funeral Director: After this certificate has been signed by the attending his minimized. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 1 ☐ Yes 2 V2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 00063681 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajit Kurup, 1835 University Blvd. #208, Hyattsville, MD20783 MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 2 2011

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pilvin September 2011 Physician/ Harold 7:15A. Medical b. City, Town, or Location of Death Potomac 4a. Facility Name (if not institution, give street and number) **Examiner** 4c County of Death Montgomery Manor Care Health Services Potomac 5. Social Security Number 7. Age (In yrs. last birthday) 89 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 016-12-2346 1 🗓 M 2 🗆 F May 1922 Massachusetts Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Bethesda 1 🗆 Yes 2 🏝 No Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20816 United States permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other the any injury or other the state of the state o Funeral 4978 Sentinel Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 1 ☐ Never Married 2 X Married þ 2 No White 1 Yes 2 No Specify: If Yes. Give Year or Dates. WII 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) World Bank Chief Economist Be 18. Mother's Name (First, Milddle, Maiden Surname) Lena Vivat 17. Father's Name (First, Middle, Last) ည Jacob Pilvin 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 4978 Sentinel Drive Bethesda, Maryland 20816 Patricia Pilvin -wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Memorial Gdns. 9/12/2011 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Bonald V.Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Man 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Lung Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. غالم Puneral Director. After this certificate has been sinned by the attending the continuation of the attending the second sinned by the attending the second sinned by the attending the second sinned by the attending the second sinned by the attending the second sinned by the attending the second sinned by the attending the second sinned by the attending the second sinned by the second sinned by the attending the second sinned by the second sinned Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) n signed by the at Id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pancy topenia 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1X Yes this certificate has been s ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner' Hospital 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 9, 2011 D50534 Masterson un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

6 2011

Thomas Masterson, M.D. 6858 Old Dominion Drive, #104 McLean, VA 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8/29/2011 Physician/ Ruth Renee Russillo 425 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Anne Arundel Harwood Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√X F 528-44-6663 Director 74 UT Usual Residence of Decedent 23a or 28a-f shov 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes XX No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22 Silverwood Circle #5 21043 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Who Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XXIIo Specify: 3 ₩idowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mex Elementary/Seconday (0-12) College (1-4 or 5+) Accounting State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Wells Illa Marsing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Teri Athey Daughter 108 Claiborne Fields Dr. Centreville, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Hillcrest Memorial 9/1/2011 Annapolis, MD permit. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD_21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Ph_ysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) the g 🗌 Unknown detached g Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? þ within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be a 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier rus

State Registrar MedecalParkway Ste210 Annapolis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
AUG 3 0 2011

2003

		1	For State of Mary		rtment of H tificate of D			2011	29712			
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Maria Theresa Romero			•	2. Date of Death Month August		3. Time of Death 5:21 p M			
	Medic Examin	al .	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	August	4c. County of Deat	th			
أفرميد	-		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	Silver S	If Under 24 Hrs.	8. Date of Birth	Montgon 9. Bird	thplace (State or Foreign			
	Funeral Director		574-16-9341 1 □ M 2 🕱 F	86 Yrs.	Months Days	Hours Min.	iarch 26	1925 Pue:	rto Rico			
	and show dat	ī		c. City, Town or Loc					10d. Inside City Limits			
	e Mary r 28a-f notifie	Director	MD Montgomery 10e. Street and Number	Silver	Spring 10f. Zip Code		10	a, Citizen of What Co	1 Yes 2 No			
	with th s 23a o ust be	Funeral	9918 Tenbrook Drive		20901			USA				
030	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The man Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural" or items 2 be notified at other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	If	Yes, specify Cubar	spanic Origin? (Specin, Mexican, Puerto Ri Specify: Puert	ican, etc.)	Black, White, etc.				
ე 	72 hour n "natu 1edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa ind of work done d NOT use retired)	ation luring most of working	g 1	6b. Kind of Business	Industry			
212	within /giene. ner tha t, the N		Elementary/Seconday (0-12) College (1-4 or 5+)		ing Aide			Nursing	Home			
and	be filed ental H ked otl ic even	To Be	17. Father's Name (First, Middle, Last) Jose Lopez			18. Mother's Name	, ,	,				
Baltımore, Maryland 21215-0036	should be file h and Mental I 7 is marked o traumatic eve		19a. Informant's Name/Relationship (Type, Print)	100				ber, City or Town, State, Zip Code)				
ē, Z	f and 2 of Health item 27 other tr		Thomas N. Galanos/Executor 20a. Method of Disposition	20b. Place of Dispos cemetery, crem Arlington	sition (Name of	Stevensv	ate 2	20c. Location - City or Town, State				
III	permit. Page 1 a Department of I Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify)			Arlington,	, VA					
Ball	permit Depart Impor any in once.	Q	21. Signature of Funeral Service Licensee	ome Inc. ver Spring	g, MD 20901							
7.	0		23a. Part 1. Enter the disease, or complications that caused the shock, or heart fallure. List only one cause on each line.	e death. Do not ente	er the mode of dying	g, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death			
	Physician/ Medical	1	Immediate Cause (Final disease or condition resulting in death) a. Cardiopul: Due to (or as a co		rest				Officer and Double			
	Examiner	<u>.</u>	Sequentially list conditions,	ock								
_	pe Zi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury									
-	icate be executed I physiciar and s the buriar transiti	al Ex	that initiated events resulting in death) Last C. Due to (or as a co	onsequence of):	· · · · · · · · · · · · · · · · · · ·							
3760	certificate be executed nding physiciar <u>i and</u> use as the buriak tipris	Medical	d		···							
Box	death ne atte ed for	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown 23c. If yes, outcome of particle of the past 12 months? 4 ☐ Pregnant at tire particle of the particl	Fetal death 3	Ectopic pregnand Other (specify)	ру		23d. Date of de Month	elivery Day Year			
ds, P.O.	requires that the dea been signed by the should be detached	ted by Pr	Part II. Other significant conditions contributing to death but I	not resulting in the u	inderlying cause giv	ven in Part I.			o the cause of death? Probably 4 🗌 Unknown			
Division of Vital Records,	The law ate has bage 2	Completed			00 80	De the Obselve	24a. Was an autops perform	y prior to	utopsy findings available completion of cause of			
Vita	Physiciant	To Be	25. Was case referred to medical examiner? 1 🖾 Yes 2 🗋 No Hospital: 1🛣 Inpatient	2 ER/Outpatier	Oth	ace of Death (Check er: 4 Nursing Hor		nce 6 Other (Spe	icify)			
n of	ding Pł h. After th funeral		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident Investigation 28a. Date of injury (Month, Day, Y	28b. Time of injury	work	y at ⟨? Yes 2 □ No	8d. Describe ho	w injury occurred				
Divisio	al or Attending P s after death. Il Director; After t d in by the funera	Certificate:		- At home, farm, stre Specify)		2	28f. Location (Str City or Town,	reet and Number or R , State)	ural Route Number,			
_	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	29a. Certifier 1	mination and/or invest	tigation in my opini	on death occurred at	the time date and	d place, and due to the	e cause(s) and manner stated. I			
_	6 ≥ 5 5	Ž	29b. Signature and title of contifier		29c. Licens	e number		9d. Date signed (Mon	oth, Day, Year)			
	20	L . 10	30. Name and address of persop who completed cause of deat	th (Item 23a) (Type, F		5069		August 29	, 2011			
0.			Sirak Lemma, MD 1500 Fo	orest Gler	n Road, S	ilver Spr	ing, MD	20910				
	Sta Registr		31. Date filed (Month, Day, Year) SEP 01 2011	Signature Aar	20							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 12:20 A M John Steven Roman August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Delaware Months (Month, Day,) eb. 15 Yea*r)* 19<u>17</u> **Director** 573-22-8906 94 Feb. Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? ö must be Completed by Funeral 23a 2816 Village Lane 20906 United States "natural", or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 No 1939 Black, White, etc 1 Never Married 2X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced 1945 Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Centers for the permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me any injury or other traumatic event, the Me Once. Elementary/Seconday (0-12) College (1-4 or 5+) Handicapped Industrial Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Felicia Roliciami Frank Carlini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2816 Village Lane, Silver Spring, MD 20906 Gladys Roman/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 \square Burial 2 X Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/31/2011 Alexandria, VA Metropolitan Crem. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ a Decompensated Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) an and Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial. that initiated events resulting in death) Last Due to (or as a consequence of): Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant
9 Unknown Pregnant at time of death 1 ☐ Yes ≥ L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Coronary Artery Disease, Coronary Artery Bypass Graft 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Artificial Cardiac Defibrillator, Mild Dementia 24a, Was an autopsy performed? Yes 2 X No Chronic Renal Failure Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural injury 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Vithin 2 only one 3 🗆 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) August 31, 2011 D0068681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910-1484 Charu Maheshwary, State SEP Registrar

			For State	State of Ma	aryland /				and N	Mental Hy	gien	e		00~	, , ,
			Registrar			Cer	tificate of	Death			Reg. N	201		291	14
E	Physicia		1. Decedent's Name (First, Middle, La Joseph Pasquale	,	ella					2. Date of De Month August		2011	ear	3. Time of	f Death
Jan 19	Medic Examir		4a. Facility Name (if not institution, giv	re street and number)			4b. City, Town,	or Location	of Death	Rugust	4c. County of Death				71
أر	LAdiiii	ICI	Suburban Hospita				Betheso	Montgom				rv			
	Funeral	-	5. Social Security Number 6.	Sex 7. Age	e (In yrs. last b	oirthday)	If Under 1 Year	8. Date of Birth 9. Bi			D: 11	1 (0)	or Foreign		
	Director		165-22-3384	1 X M 2 □ F 8	1	Yrs.	Months Days	Hours	Min.	March 2	21, 1930 Sountry PA				
	t ow	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, To		ation .						<u></u>	0d. Inside C	Star Lincoln
	ırylan a-f sh ied a	Director	MD Montgo	merv		nsin									s 2 XNo
	or 288	E.	10e. Street and Number				10f. Zip Code		T	10a (Citizen of Wha	t Cour		, , , , , , , , ,	
	vith th	ra	4301 Knowles Av	onuo.			20895					10g. Citizen of What Country? USA			
	ems r mu	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. \	Vas Decedent of	Hispanic Ori	gin? (Spe	ecify Yes or No-		14. Race - /	Americ	an Indian.	
ဖွ	ter de or it mine	by	1 Never Married 2 Married	Armed Forces?			If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Black, V			
93	ural", ural",	ed	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates.	Year or Dates. 1932-34			1 ☐ Yes 2 ☒No Specify:				Specify: W	White		
5-("2 hor " "nat edica	ble	15. Decedent's (Specify only highest g		16	(Give I	lent's Usual Occu	during mos	t of worki	ing	16b.	Kind of Busin	ess Inc	dustry	
21215-0036	thin ene. than he M	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	+)		O NOT use retired ctrician	,			R	etail			
d 2	ed wi Hygik other ent, t	Be (17. Father's Name (First, Middle, Last)						er's Name	e (First, Middle,					
an	be til ental rked ic ev	မ	Domenic Pasquale	Ricciarde	11a					Campana		,			
ary	nould Ind M s mai		19a. Informant's Name/Relationship (9b. Mailir	g Address (Stree					or Town, State	a, Zip C	Code)	
Σ	d 2 sl salth a n 27 i		Vincent Ricciarde	:11a/Son		2303	Honeyst	one W	ay,]	Brookev	111	e, MD	208:	33	
ore	of He of He fiten roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Romoval from State			sition (Name of natory or other pla	ace)		Date ept. 2,	20c.	Location - Cit	y or To	wn, State	
<u>Ĕ</u>	perfinit. Page I and 2 should be filed within 12 hours after death with the waryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Spec			-	eaven Ce		у	2011	S11	ver Sp	rir	ıg, MD	
Baltimore, Maryland	Sermit Separt mpor iny inj		21. Signature of Funeral Service Licer	nsee		F1	Name and Addr	ess of Facili	ins	Funera]	l Hc	me Inc			
	0.0 = 6 6		1500 University Blvd. W., Silver Spring.												
			shock, or heart failure. List only	one cause on each line							rest,			Approxima Interval Bet Onset and	tween
P	nysician/ Medical		disease or condition resulting in death)	Intracra			rhage,	Non-Tr	auma	tic			-		
-	Examiner			Due to (or as a Hyperter		e ot):									
		Je.	Sequentially list conditions, if any, leading to immediate	b. Sue to (or as a		o oly:									
3	1	ä	cause. Enter Underlying Cause (Disease or iinjury that initiated events												
	an an right	ŭ	resulting in death) Last	Due to (or as a	consequenc	e of):							\top		
09	physician and the burial trapsit	dical Examiner		d									+		
87	ing pl		IF FEMALE:												
0 × 6	ttend or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🗌 Fetal de			ncy			ĺ	23d. Date o Month			Year
ĕ	the a	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	n 5L	Other (specify)							24,	
P.O. Box 687	ed by detac	F.	Part II. Other significant conditions	contributing to death bu	ut not resultin	g in the u	nderlying cause (given in Part	l.	23e. Did t	obacco	use contribu	te to th	ne cause of (death?
S,	sign Id be	Completed by Physician/Me	Dementia, Hyperl	ipidemia						1 🗆	Yes :	2 [¥] ∑ No 3 [☐ Prol	oably 4 🗆	Unknown
ord	s beer shou	Set								24a. Was				psy findings	
Sec	te has	E	-							auto perfo 1 \square Yes	psy ormed?	prio dea	th?	mpletion of a	cause of
<u>Е</u>	tifical tor, pa	BeC	25. Was case referred to medical	Ī			26.1	Place of Dea	th (Check		2 🔁 1	NolIL	res	2 LI NO	
Z K	r this certifica ral director, p	10 B	examiner? 1 XYes 2 No	Hospital:	ent 2 ER/	Outpatier	t 3 🗆 DOA Ot	her: 4 🗆 N	ursing Ho	ome 5 🗆 Resi	dence	6 ☐ Other (S	Specify)	
o	fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injur (Month, Day,		. Time of injury	28c. Inju	ıry at rk?		28d. Describe h	now inju	ury occurred			
ion	leath.	ijič	2 Accident Investigation	he				Yes 2	No No						
Division of Vital Records,	The interpretation and attending right and in the law requires that the beath certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial traces.	Certificate:	4 Homicide determined		ry - At home, . (Spec <i>ify)</i>	farm, stre	et, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)				ber,	
	hours neral d filled	Medical	29a. Certifier Certifying Ph	ysician: To the best of r	my knowledg	e, death o	ccured at the tim	ne, date and	place, an	id due to the ca	ause(s) a	and manner a	s state	d.	
3	une na nin 24 t he Fu nplete	Mec		niner: On the basis of ex rse Practioner: To the b											anner stated.
-	E MILE		29b. Signature and title of certifier	(29c. Licen	se number	1		29d. D	ate signed (//	lonth, l	Day, Year)	
	1041		N. 11-	" The			リリチ	12	1+		0	1311	/ (
			30. Name and address of person who Natalia Vasquez	completed cause of de , MD 8600	eath (Item 23a) 01d () (Type, P Georg	rint) etown Ro	oad, E	ethe	sda, MI	20	814			
	Sta		31. Date filed (Month, Day, Year)		r's Signature			-							

Registrar

SEP 01 2011 Server B. gard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:50 P M 08 ont 7-20 1 WALTER CLARENCE ROSSER, JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Capitol Heights 4907 Heath Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🕎 M 2 🗆 F Min 0 Monto Bay 19948 Months Hours PA 184-38-6395 63 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director Prince George's 1X Yes 2 □ No Capitol Heights MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 20743 USA 4907 Heath Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. þ 1 Never Married 2 X Married 1 Ves 2 No If Yes, Give Year or Dates 967-70 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 College (1-4 or 5+) Federal Gov't Special Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Grace Puryear Walter Clarence Rosser, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4907 Heath St., Capitol Heights, MD 20743 Mary Ann Ellis Rosser/wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1) Burial 2 Cremation 3 X Removal from State D8-23-2011 Elizabeth, PA 4 ☐ Donation 5 ☐ Other (Specify) Round Hill Cem. 20746 Signature Juneral Service Licensee 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave., Suitland, Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Fatal Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause E ster Us Jerryi sy Cause (Disease or iinjury Due to (or as a consequence of). that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23h. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day 2 No 9 Unknown a Dinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cancer of rectum, DM, HTN, High Cholestrol 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? rmed? 2 X No 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 X No မ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural
Accident
Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Director: /

State Registrar

Medical

W. McConnell, MD 1221 Mercantile Lane, Largo, MD 20774 32. Registra 's Signature 31. Date filed (Month, Day, Year) SEP 0 2 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation

determined

6 Could not be

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0029654

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year) 08-19-2011

City or Town, State)

State of Maryland / Department of Health and Mental Hygien 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8/27/2011 Physician/ Lucile K. Siegert 120pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis <u>Anne Arundel</u> Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2XCXF Days Hours 2/4/1918 578-12-3469 Director 93 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel 1 Yes 2XXNo Severna Park 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with t ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a Funeral 266 Shakespeare Dr. 21146 USA . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White 3XXWidowed 4 ☐ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Kirchner Gertrude I. Bullin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5155 Players Way Glenwood, MD 21738 |Sue A. Folks Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Quaker Burial Ground! 8/31/2011 | Galesville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. J 77 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Sipsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Lower Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ☐ Pregnant at time of death Month Year the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Junknown Completed COPL 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 1100 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? s after death. 2 🗌 No ☐ Accident ☐ Suicide Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical We certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 014089 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway Angpo Nedira 2001 nrk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Clarita Stroberg Aug :22a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Spring House Silver Spring Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Oct 27, 191 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 🗆 M 2 🗓 F Months Days Hours **Director** Yrs 578-48-5437 Chicago Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland **Funeral Director** L Yes 2 □ No MDMontgomery Silver Spring 10e. Street and Number 2201 Colston Dr 10f. Zip Code 10g. Citizen of What Country? 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Personnel Specialist other Fed Govt Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any liury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 August Eric Clausson Marie Lampe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne W. Noll/Executor 5202 Danbury Rd, Bethesda, MD 20814 Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Elmwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Sept 6,2011 Sycamore, IL 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Joseph Gawler's Sons, INC MIC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Failure to Thrive Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed burial-Itage Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 💢 No Month Day Year signed by the at d be detached for 1 Yes 2 X P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Anemia or Attending Physician: The law requires 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? Yes 2X N certificate 2 🗆 No 1 Tyes 1 Tes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 $\overline{\mathbf{x}}$ Other (Specify) $\overline{\mathbf{Assited}}$ $\overline{\mathbf{Liv}}$ $\overline{\mathbf{ir}}$ 2 **X**No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Completed filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 5 Pending work? Division 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 31,2011 D63232 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15245 Shady Grove Rd #130, Rockville, MD 20850 Patricia Gomez, M.D.

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year) **SEP 012011**

2. Registrar's Signature

11-06167 Thelma Steele

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certifica	ate of Death	Reg. No.					
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,La THELMA ELAINE	-		2. Date of Death Month Day Year August 15, 2011	3. Time of Death 2042 hrs				
	4a. Facility Name (if not institution, given 2910 East Avenue	re street and number)	4b. City, Town, or Location of Death Forestville	Prince Ge	eorge's				
Funeral Director		ex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24Hr Months Days Hours Mir		Birthplace (State or Foreign Country)				
Maryland 28a-f show any d at ouce.		George's Fore	stville	10a. Citizen of Wha	10d. Inside City Limits 1 X Yes 2 No				
the Maryland a or 28a-f sho tiffied at once	10e. Street and Number 2910 East Avei	nue	10f. Zip Code 20747	USA					
death with or items 23 must be no	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto Yes 2 No specify:		White, etc.				
5-0036 ed within 72 hours afthe fygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	tired)	iness/Industry				
21215-0036 Juld be filed within 7 Montal Hygiene. marked other than ic event, the Medica	17. Father's Name (First, Middle, Las Joseph Daniel	ther's Name (First, Middle, Last) seph Daniel 18.Mother's Name (First, Middle, Maiden Surname) Sarah Ann Woodyard							
MD 21; d 2 should b th and Men an 27 is mar numatic eve	19a. Informant's Name/Relationship (Susan Vasquez,		b. Mailing Address (Street and Number or 3295 Grayton Ln.,		n, State, Zip Code)				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by I	20a. Method of Disposition 1	Removal from State Cedar			and, MD				
Balti permit. Departu Import	21. Signature of Funeral Service Lice	1	22. Name and Address of Facility Cedar Hill FH, 4		Suitland, MD				
Physician Medical	23a. Part I. Enter the disease, or comfailure. List only one cause on a	Approximate Interval Between Onset and Death							
Examiner	or condition resulting in death)	Multiple Injuries Due to (or as a consequence of):							
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	_						
760, icate be executed physician and the burial - transit	UNPENDED	AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi fedical Certification: To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknow	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify)							
ords, P.O. Box 687 wrequires that the death certificate been signed by the attending should be detached for use as the pleted by Physician!	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause given in Part I.		Probably 4 Unknown				
Division of Vital Records, tal or Attending Physician: The law require rs after death. *I Director: After this certificate has been sited in by the funeral director, page 2 should be entification: To Be Completed				autopsy performed?	Were autopsy findings available prior to completion of cause of leath? Yes 2 No				
Vital Rechysician: The Inthic certificate Indirector, page	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/C	26.Place of Death (Chec Outpatient 3 DOA Other 1 Nurs	k only one) sing Home 5 Residence 6	Other: Scene				
n of Vi ading Physi ih. : After this e funeral di	27. Manner of Death 1 Natural 5 Pending	Aug 15 2011 202	Time of Injury 28c. Injury at Work? 23 hrs 1 Yes 2 No	28d. Describe how injury occurr Subject was assaulted	ed				
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune fedical Certification:	2 Accident Investig: 3 Suicide 6 Could not determine	ot be 28e. Place of Injury - At home,	farm, street, factory, office building, etc. Home	28f. Location (Street and Numbor Town, State) 2910 East Avenue, Forestvil					
To the Hospi within 24 hours To the Funeu completely fi	29a Certifier	clan: To the best of my knowledge, de er:On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, a investigation, in my opinion, death occurred	d at the time, date and place, and d	lue to the cause(s)				
W Figure 8	Samela Pirishall.	29d. Date sign August 16,	ed (Month, Day, Year) 2011						
RS	Pamela E. Southall, MD		er 900 W. Baltimore Street, Ba	Itimore, MD 21223					
State Registra	31. Date filed (Month, Day Year) SEP 0 2 2011	32. Registral Signal re	es .	OCME					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER Physician/ SPROUSE LUCILLE LOUISE 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner ATA 8. Date of Birth 9 Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Days NOV Day Yes ^{Year}1921 Min. Hours 1 M 2 F Months PENNSYLVANIA 89 Director 218-38-9086 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director BRYANS ROAD CHARLES MD 1 Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U. S. A. 6670 BUCKNELL ROAD 20616 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in ILS Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 🗌 Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates. Specify: WHITE 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S.CUSTOMS SERVICE LIBRARY TECHNICIAN 12 ROUSE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOSEPH KENNEDY ALLISON ELIZABETH A. HOWARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20616 19a. Informant's Name/Relationship (Type, Print) 6670 BUCKNELL RD., BRYANS ROAD, MARYLAND PATRICIA GIVENS/DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) SEPPEMBER 1 🗶 Burial 2 🗆 Cremation 3 🗀 Removal from State WALDORF, MARYLAND TRINITY MEM.GRDNS. 15,2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service Licensee 5635 WASHINGTON AVE., LA PLATA, MD_20646 -clw 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. etastatic Onset and Death Concer Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a nonsequence of) if any, leading to infinediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Year in the past 12 months? Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has page 2 s performed Yes 2 2 No 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 😿 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 Tes this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: After (Month, Day, Year) 5 Pending 1 🔀 Natural ithin 24 hours after death.

the Funeral Director: Ai
ompleted filled in by the fu Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examing: On ye basis of examination and the investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cortifying the region at To the best plant from logic draft occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check noner to the best of any knowledge, death contin within 2

To the F

complet Certifying Nursy Pray Orny offe) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 9 9/10/11 0 Er 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

OLLIN

SOUTHERN MARYLAND PRIMARY CARE, 3460 OLD

WASHINGTON RD, SUITE 203 A

WALDORF, MD 2060

M.D.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08/5<mark>1</mark>/5077 14:40 P M Charles Edward Tavlor Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 6713 Edgemere Dr. Camp Springs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 **X** M 2 □ F 227-48-1775 Days 12/27/1941 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d, Inside City Limits Director MD Prince Georges Camp Springs 1 X Yes 2 No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 **AZU** 6713 Edgemere Dr death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 is and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Electrician Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Evelyn Taylor Ben Tavlor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 6713 Edgemere Dr., Camp Springs, MD 20748 Ann B. Taylor / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State MD Veterans Cemetery : 08/29/2011 4 Donation 5 Other (Specify) Cheltenham, MD 21. Signatus of Funeral Selvic L 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Atherosclerotic Cardiovascular Heart Disease disease or condition resulting in death) Medical Examiner 5 squartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death Other (specify) be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an las l autopsy performed?
Yes 2 X No prior to completion of cause of death? certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 | No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending s after death. Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Boute Number upleted filled in by 4 Homicide determined within 24 hours a To the Funeral D To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
SEP 0 2 2011

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death . Decedent's Name *(First, Middle, Last)* Gladys Ann Thomas 2. Date of Death September 8, 2011 Gladys 2:42A. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Takoma Park Washington Adventist Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours March 17, 1939 Washington, DC 1 ☐ M 2 🖫 F 72 578-50-8959 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1X Yes 2 □ No College Park Director Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20740 8411 Patuxent Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married White 1 □Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel Stinson James Sprouse ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8411 Patuxent Avenue College Park, Maryland 20740 19a. Informant's Name/Relationship (Type. Print)
Donald C. Thomas, Sr. -husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/13/2011 Cedar Hill Cemetery Suitland, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of): 4 mbhoma Sequentially list conditions, Due to (or as a consequence of) Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2-No 11 Impatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, certificate

cate has been signed by the page 2 should be detached After this certific funeral director, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu filled in by

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marinal Examination and once.

Physician

Examiner

/Medical

altimore, Maryland 21215-0036

Medical

29a. Certifier (Check only one) 29b. Signature and title of certifier

JANNA

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number DO064024 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LACKETCHININA, M.D.

31. Date filed (Month, Day, Year) State 1 6 2011 Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 29, 2011 Year Sylvia WOLINSKY 6:20 P ^M 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Hebrew Home of Greater Washington 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. 1917 1□M 2XF Pennsylvania 93 185-07-3530 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □ Yes 2 No Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 United States 6105 Montrose Road #4143 E 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 9 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Colton Benjamin Voron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7.7 Markon Count Potomac, MD 20854 19a. Informant's Name/Relationship (Type. Print) 10041 Chartwell Manor Court, Potomac, MD Joseph Wolinsky, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 09/01/11 Adelphi, MD Mt. Lebanon Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Huneral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, 20012 Approximate Interval Between Onset and Death 23a. Part I. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dementia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe death? 2□ No 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation

Physician /Medical Examiner

Examine

Physician/Medical

Completed

Certification: To

Medical

State

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

sician and sician sit The law requires that the death certificate be executed attending physician for use as the buria funeral director, page 2 : To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica

Division or Vital Records, P.O. Box 68760.

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

6 ☐ Could not be

D00648

29d. Date signed (Month, Day, Year) 8-30-2011

Rockville MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Rd

Fazli 31. Date filed (Month, Day, Year)

01 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 29 Day Physician/ $201^{Y_{\hat{\mathbf{I}}}^{ar}}$ 3:44 A M MICHAEL В. WALKER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🛣 M 2 🗆 F Months Hours Month, Day, Y April 25 577-76-4139 54 Chamber Cty. Al **Director** .1957 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 Yes 2 □ No Forestville Maryland Prince Georges 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with United States 20747 7008 Beltz Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner Black. White, etc. o. þ 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 al Hygiene. d other than "natural", c event, the Medical Exan Specify: Black 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Engineer Government 11th traumatic event, Be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental | 7 is marked o မ Page 1 and 2 should be Willie Garlington Nolan WAlker, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i Willie Walker / Mother 7008 Beltz Dr. Forestville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Lincoln Memorial 9/3/2011 Suitland, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liv 22. Name and Address of Facility Alexander S. 5538 Mariboro Pope P.A. Pikė Forestville, Md. 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Examine Due to for an a donnaquental off or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical P.O. Box 68760 IF FEMALE nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? for Pregnant at time of death detached Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Tyes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 \square Pending work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 24 hours after c Funeral Direct determined building, etc. (Specify) Hospital Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09/ 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day Year FRANCES HOPE WELLS 1046am 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Peninsula Regional Medical Wicamico conte If Under 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Hours 5 M 10 - 19 48 WEST VIRGINIA 218-48-9828 63 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No SUSSEX DELAWARE DAGSBORO 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 129 CREEKSIDE DRIVE 19939 US items 2 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 9 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE "natural", 3 Widowed 4 Divorced Completed and Mental Hygiene.
is marked other than "naturraumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT RELATIONS EXECUTIVE ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 PAUL RAYMOND DADDYSMAN VIOLET PETTET permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE T. WELLS/HUSBAND 129 CREEKSIDE DR, DAGSBORO, DE. 19939 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date injury or 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place)
MELSON'S CREMATORY 8-30-2011 FRANKFORD, DELAWARE 4 Donation 5 Dother (Specify) 21. Signature of Funeral erv 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LTD any 19970 <u>38040 MUDDY NECK RD. OCÉAN VIEW.</u> 23a. Part 1. Enter the disease, shock, or heart failure Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Preumania disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Years Cancer Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): ding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No or Pregnant at time of death Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No Certificate: To 1 V Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 \square Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. noleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 29c License numbe 29d. Date signed (Month, Day, Year) D70053 august 28 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8A 10 100 K

DHMH 17 Rev 7/2009

State

Registrar

AUG 31

2011

31. Date filed (Month,

Pegistrar's Signature

		S	be or Print in Blac l tate of Maryland / D			•	•	•		
	•	State Registrar		Certificate of L			eg. No 2011	29725		
Physicia Medic		Decedent's Name (First, Middle, Last)	Shirley	YAFF	EE	2. Date of Death Month August 2	^{Day} 2011	3. Time of Death 11:10 P _M		
Examin	er	4a. Facility Name (if not institution, give street 15115 Interlachen Dr			r Location of Death r Spring		4c. County of Death Montgomery			
Funeral Director		5. Social Security Number 6. Sex 195-12-1282 1 □ M	7. Age (In yrs. last birtho		If Under 24 Hrs. Hours Min.	8. Date of Birth Feb. 5,	g Bi	rthplace (State or Foreign		
	ır	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		100.0,	1322 10	10d. Inside City Limits		
Marylar 28a-f sl otified	irecto	Maryland Montgomery		ver Spring				1 🗆 Yes 2 💢 No		
with the 23a or	Funeral Director	10e. Street and Number 15115 Interlachen Dr	rive #521	10f. Zip Code 2090	16	1	Og. Citizen of What C United St	*		
or items	by Fun	11 Marital Status 12. V	/as Decedent Ever in U.S. rmed Forces? □ Yes 2 🕅 No	13. Was Decedent of H If Yes, specify Cuba			14. Race - Ame Black, Whit			
ours afte atural", al Exar	eted b	2 NACHALINA 4 Dispersed	Yes, Give ear or Dates.	1 ☐ Yes 2 🖾 No			Specify: wh			
hin 72 h ne. than "na e Medi k	Completed	(Specify only highest grade co	mpleted) ((Decedent's Usual Occup Give kind of work done of ife. DO NOT use retired)	during most of work	ing [16b. Kind of Business National I			
filed wit al Hygie d other vent, th	Be	17. Father's Name (First, Middle, Last)	4	<u>Grant Assis</u>	18. Mother's Nam		of Health Maiden Surname)			
ould be nd Ments marked imatic e	10	Benjamin Baun		Molling Address (Street	Lena E		City on Town State 7	20906		
ind 2 shi lealth ar im 27 is her trau		Philip Yaffee, Husba	ind 15	Mailing Address (Street a 115 Interla	ichen Driv	/e, #521	, Silver S	pring, MD		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3X Remo 4 Donation 5 Content (Specify)	cemetery.	Disposition (Name of crematory or other plac vid Memoria	(e)		20c. Location - City o 1 Falls C	r Town, State hurch, VA		
permit. Departi		21. Signature of Lineral Service Libensee	M01008	Torchinsky 254 Carrol				20012		
		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ons that caused the death. Do no se on each line.					Approximate		
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Respiratory Fai Due to (or as a consequence of)	lure				24 Hours		
Examiner	ner	Sequentially list conditions, b> If any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):						
and	Examiner		Scleroderma Due to (or as a consequence of)·		<u> </u>				
auth certificate be executed attending physician and for use as the burial-transit	cal	d								
certifica anding p use as t	an/Me	20b. 44d3 decedent pregnant	yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death	3 ☐ Ectopic pregnand			23d. Date of de	elivery		
the death by the att	by Physician/Medi	1 Ves 2 VNo	Pregnant at time of death Unknown	5 Other (specify)	-y 		Month	Day Year		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	d by P	Part II. Other significant conditions contribu	ting to death but not resulting in	the underlying cause giv	ven in Part I.			o the cause of death?		
law requ has beer e 2 shou	Completed					24a. Was ar autops	y prior to	utopsy findings available completion of cause of		
ian: The rtificate stor, pag	Be Co	25. Was case referred to medical examiner?		26. PI	ace of Death (Chec	perform 1 Ves 2 k only one)		es 2 🗆 No		
Physic r this ce aral direc	70	1 Yes 2 No	al: 1 Inpatient 2 ER/Outs Ba. Date of injury 28b. Tir		4 L Nursing Ho	ome 5 XReside 28d. Describe ho	nce 6 Other (Spe	cify)		
tending Jeath. tor: Afte the fune	Certificate:	1/\int Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		ury work M 1 □		20d. Describe no	w injury occurred			
tal or Al	al Cert	4 Homicide determined	e. Place of Injury - At home, farn building, etc. (Specify)	n, street, factory, office		28f. Location (Str City or Town,	reet and Number or Ri , State)	ural Route Number,		
ne Hospi in 24 hou ne Funer pleted fill	Medical	(Check / 12 L Medical Examiner: C	To the best of my knowledge, denote the basis of examination and/or pioner: To the best of my knowled	investigation, in my opinio	on, death occurred a	t the time, date and	d place, and due to the	cause(s) and manner stated		
Within To the Control of the Control		29b. Signature and title of certifier	DRIC LL	100	HORT		9d. Park signer (Mon	th, Day, Year)		
		30. Name and address of person who complete Penny L. Bisk, M.D.,	ted cause of death (Item 23a) (Ty 10301 Georgia	Ave., Suite	e 301, Si	lver Spr	ing, MD 2	20902		
Stat Registra		31. Date filed (Month, Day, Year) SEP 01 2011	3/. Registrar's Signature	faces						
Tieglotte	000	DEL AT SALL	Commo p. 17							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 5:16 PM **Physician** 10 2011 Deptember ames /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Johns Hopkins Bayview Medical Center Raltimore 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 5, 1950 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 [XM 2 □ F 241-86-6229 Director Usual Residence of Decedent 10d Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show "natural", or Items 23a or 28a-f sho dical Examiner must be notified at 1X Yes 2 ☐ No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ت عدمات الله should be filed within 72 hours after death with الله hand Mental Hygiene. USA 21224 8020 Gough Street Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status 1 X Never Married 2 Married black 1 ☐ Yes 2 X No 3altimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education the Medical (Specify only highest grade completed) College (1-4 or 5+)
unk Elementary/Secondary (0-12) construction foreman unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental I Ida Atkinson Brian Atkinson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8020 Gough Street; Baltimore, MD 21224 Tomeka Tabron - friend Health tem 27 Department of Healt Important: If Item 2 any Injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signature of Fundal Service Lice Wade 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiopulmonary **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner letastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy Month Year in the past 12 months? for Pregnant at time of death 5 Other (specify) 2 No detached f 9 Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes certificate has been sig lirector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 | No 1 ☐ Yes 2 No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 R/Outpatient 3 🗌 DOA 1 🗌 Inpatient မ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death Certification: nin 24 hours after death.

the Funeral Director: After t

mpletely filled in by the funer Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

29a. Certifier

(check only one)

29b. Signature and title of certifier

Sadore

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eldman

32. Registrar's Signature park

within 2.

To the F

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

stember 10, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ AUGUST 26PM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest Hospital Randallstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 08 | 25 | 36 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthdav **Funeral** 1 M 2 SF 217-38-1820 **Director** 74 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore 1 🗌 Yes 2 🔀 No MD Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8606 Bramble Lane 21133 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ۵ ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 6th grade Cook Restaurants na Be 18. Mother's Name *(First, Middle, Maid*en S*ur*na*me)* Mollie Winbush and 2 should be filed 17. Father's Name (First, Middle, Last) Willie Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Roberta Boston-Daughter 5610 Woodmont Ave, Baltimore, Md 21239 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot Page 1 cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 A Donation 5 Other (Specify) On-Site 8/16/2011|Baltimore, Md permit. 22. Name and Address of Facility
March F/H West 21. Sign f Funeral Service Licensee 4300 Wabash Ave, 21215 Baltimore, 23a. Parti1. Enter the disease, or complications that caused shock, or heartfailure. List only one cause on each line Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, CANCER Ph_sician/ OLON Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): #24q of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ sate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> DISEASE CORONARY ARTERY 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 XInpatient 2 I ER/Outpatient 3 I DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ertifier 29d. Date signed (Month, Day, Year) August 12, 2011 W HB3 HPROH TZ3W BOSPITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 OLP ROBO VVERAHALLI HARISH M 31. Date filed (Monthy Day, Year) ## V State tarka Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gregory Tal Bostia	1	- For State	St	ate of Mary	land /	Departm Certific			d Ment	al Hygi		eg. No.	201	1 29	728
Physician		legistrar I. Decedent's Name	(First, Middl	le,Last)					<u>-</u>		Date of Dea	th	Year	3. Time of Dea	ath
Medical Examine		Gregor			stiar	n					Month Septembe			1500 hrs	
	1	ta. Facility Name (if Frederick Mo		. •	number)			4b. City, Town, or Frederick	Location o	f Death	Frederick			ath	
Funeral	*	5. Social Security N	umber	6. Sex	7. Age	(In yrs. last bir	thday)	If Under 1 Year Months Day	_	_	. Date of Bir	th (MM/D	For	Birthplace (State o eign	
Director		216-88-17		1X M 2 F		48	Yrs				July 1	11,	1963	Country)Mary	land
any	- 1-	Jsual Residence of I0a. State	Decedent 10b. County		1	0c. City, Town	or Locat	ion						10d. Inside Cit	ty Limits
	_ ,	Maryland	Fre	ederick				ጥት	urmon	nt				1 Yes 2	X No
the Maryland a ur 28a-f sh tifted at onc	3	10e. Street and Nun						10f. Zip Code			1	0g. Citiz	ountry?		
th the Maryland 23a ur 28a-f shu notified at once.	5	5110 W	igvill	e Road				21	788				U.S.A	۸.	
5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", ur items 23a nr 28a-f shi the Medical Examiner must be notified at once Commission by Firnaral Director	P .	I1. Marital Status 1	d 2 XM	12. Was D	Forces?_	_		s Decedent of His es, specify Cubar				1	 Race - Am White, etc 	nerican Indian, Blad :	ck,
ter de:		3 Widowed		orced If Yes, Give Y		X No	1	Yes 2X No	specify:			5	Specify:	White	
ours aft	3 -	15. Decedent's Ed		or Dates:		leted) 16a.		it's Usual Occupa	tion (Give k			16b. Ki	nd of Busines		
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan		Elementary/Seco	ndary (0-12)	College	(1-4 or 5+			ost of working life							
5-0036 iled within 77 Hygiene. 3 other than the Medical		17. Father's Name (2	I anth		tr	immi	ng & rem			es rst, Middle, I		ree se	ervice	
		Millard		•					TO.IVIOLITO	•	rley				
D 2121 should be fi and Mental 7 is marked natic event,		19a. Informant's Na				19	b. Mailing	Address (Street	et and Num					ate, Zip Code)	-
h, MD sand 2 shou leath and 1 tem 27 is retraumatic		Vicki Bo		wife				Wigville					D 2178		
		20a. Method of Disp		n 3 Removal	from State			ition (Name of ce her place)	metery,	D	ate	20c. L	ocation - City	or Town, State	
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5	Other S	pecify:			l Ce	metery		9/17/	/2011	nr	. Libe	ertytown,	MD
Baltimo permit. Page Department of Important: injury nr ott	1	21 Signature of Fur		Licensee	126	2		lame and Address							
Physician	1	23a. Part I. Enter the	e disease, or		Caused th	ne death. Do n	ot enter t	4 S. Mai	such as ca	rdiac or re	spiratory arr	est, shoc	MD 217 ck, or heart	Approximate	
Medical Examiner		failure. List on! Immediate Cause (f		A 4-T	oscle	rotic	Card	iovascul	ar Di	sease	2			Between On Deat	
zxaiiiiiei		or condition resultin		Due to (or as											
4		Sequentially list cor if any, leading to im		b Due to (or as	a conseq	quence of):									
		eause. Enter Under (Disease or injury th	nat initiated	c. Due to (or as											
), be executed ician and urial - transit	֓֞֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֟	events resulting in o	death) Last	d.	a conseq	querice or).									
be executed be executed be urial - transional Figure 1	3	X UNPENDED		AMENDE	23a,	27,per	me,	g923 1–9	-12 s	m					
	_	F FEMALE: 3b. Was decedent p	oregnant in th			e of pregnancy							Date of deliv		
Box 6876(death certificate the attending physical for use as the box solutions.		past 12 months		I LIVE		me of death		tal death 3 her (Specify)	Ectopic	pregnancy		1.	Month	Day Y	ear
the death certificate the death certificate by the attending phyched for use as the Physician/M		1 Yes 2 N		known 9 Unl											<u> </u>
P.O.		Part II. Other signif	icant condit	ions contributing	to death	but not resultin	ig in the ι	underlying cause	given in Par	rt I.	23e. Did to			to the cause of de	
quires 1	3										24a, Was			autopsy findings a	
Records, The law requires freate has been sig									_		autop perfo	osy rm <u>ed</u> ?	prior death	to completion of ca	use of
tal Rec		25 14/	- d todis-					26 Place	e of Death (Chack anly	1 Yes	2 No	1 🗸	Yes 2	No
of Vital Records, P.O. ng Physician: The law requires that the office that the certificate has been signed by meral director, page 2 should be detach on To Re Completed by P.	١٥	25. Was case referrence examiner?		Hospital: 1	Inpatient	t 2 ✓ ER/O	utpatient		O#	Nursing H		Resider	nce 6 Ot	her:	
n of Vi	_	27. Manner of Death	No No	28a. Da	te of Injury	28b.	Time of I		ıry at Work	? 28	d. Describe	how inju	y occurred		
Sion Attending death.		1 X Natural 2 Accident	5 Pend		,,,	,		1 1	Yes 2	No					
Division of Vital Records, P.O. Box 68766 the Hospital or Attending Physician: The law requires that the death certificate him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physpitely filled in by the funeral director, page 2 should be detached for use as the bitcal Certification: To Be Completed by Divisician/Medical Certification:		3 Suicide	6 Coul	ld not be 28e. Pl		ry - At home, f	arm, stre	et, factory, office I	building, etc	28	f. Location (or Town, S		nd Number or	Rural Route Numb	er, City
Copits thours uners ly fille	3	4 Homicide 29a. Certifier		hysician: To the b		knowledge de	ath occur	rred at the time. d	ate and nia	ce and due	e to the caus	se(s) and	l manner as s	tated	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	3			miner:On the basi and manne	s of exami										
To with	Ē :	29b. Signature and	title of certifie		Stated.		_	29c. Licens	se number			29d. D	ate signed (Month, Day, Year)	
	1	MI	un B	rassel.	ME	5		O.C.	M.E.			Sept	ember 14	, 2011	
	ļ	Name and addre				,	900.14	/ Raltimara S	Street Pr	altimore	MD 212	23			
10 Stat		Melissa Bras		Assistant M		Signature	500 V	/. Baltimore S	AILEEL, BE	animore,	1VID 2 12				
Registra	ar	-,	DEP I	9 2011	ann	w 1.	1	ares							
DHMH 17 Rev 1/2001	1	(CME			OF	RIGINA	L							

			Please	Type or Print in Black Indelible Ink. Ens									
			For State	State of Maryland / Department of Health	and Mental Hygiene 2011 29729								
			Registrar 1. Decedent's Name (First, Middle, Last	Certificate of Death	2. Date of Death 3. Time of Death								
	Physicia Medi	cal	Ella (e. 4a. Facility Name (if not institution, give	e Creek	Month 9 Day Year 9:15 AM								
-	Examir	ier	Union Memo		24 Hrs. 8. Date of Birth Min. Month, Day, Yearl 20 Churgh?								
	Funeral Director		217-24-3133	Months Days Hours Min (Month Day Year)									
	and show	5	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	Min. Month, pay, Year 930 Nour Carolina 10d. Inside City Limits								
	Maryla 28a-f	Director	MD	Baltimore	Yes 2 No								
	s filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral D	1306 E. 33 PD	Street 2121B	10g. Citizen of What Country?								
(0	er death	y Fur	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No									
215-0036	rurs afte tural", al Exar	Completed by	3 Widowed 4 □ Divorced	Year or Dates. 1 ☐ Yes 2 No Specify.	Specify: Black								
215-	72 ho an "na Medic	mple	15. Decedent's Ed (Specify only highest grad	ucation de completed) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during mos	t of working Business Industry Bustineere Crify								
2	ed within Hygiene. other tha	Be Co	Elementary/Seconday (0-12)	Lyears Hovent leacher L	iason fublic schools'								
anc	ould be filed d Mental Hy marked oth matic event	To B	17. Father's Name (First, Middle, Last) Edward Por	18. Moth	er's Name (First Middle, Maiden Surname)								
Maryland	shot and is n		19a. Informant's Name/Relationship (Ty)	Tob. Mailing Address (circuit and Assiran	er or Rural Route Number, City or Town, State, Zip Code)								
	1 and 2 s of Health item 27 other tra		20a. Method of Disposition	20b. Place of Disposition (Name of	Street, Balto.mp 21218 Date 20c. Location - City or Town, State								
altimore,			1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State cemetery, crematory or other place)	9/2/2011 Owings Mills AD								
Balt	permit. Page Department of Important; If any injury or		21. Signatur of Fune LS Avice License		20 Roto MD 21212								
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the death. Do not enter the mode of dying, such as e cause on each line.	Jan 3130010 1 -								
. alix	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	. Gastrointestinal bleed	Onset and Death								
-	Examiner		arm moreov consequent	Due to (or as a consequence of): Probable Arteriovenous	malformation								
	sit sd	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or finjury	Due to (or as a consequence of):									
	executed an and ial-transi		that initiated events resulting in death) Last	C									
09,	e 55 =	dical		d									
Box 68760	death certificate b ne attending physied ed for use as the b	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	23d. Date of delivery								
. Box	de ed	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) g ☐ Unknown	Month Day Year								
P.O.	s that the		Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part									
rds	require been si should I	eted	Dishet	y Mycarcasian	1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available								
3ec	rsician: The law i s certificate has k lirector, page 2 s	Completed by	Chuni	2 obstactive long disease	autopsy prior to completion of cause of death? 1 2 Yes 2 No 1 Yes 2 No								
tal	ician: T	Be	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)								
of Vi	g Physi er this c eral dir	e: To	27. Manner of Death	1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ 4 ☐ N 28a. Date of injury 28b. Time of 28c. Injury at	ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred								
ion	tending leath. or: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) injury work? M 1 □ Yes 2 □	No								
Division of Vital Records,	al or Att	Cert	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
_	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 L Medical Examin		ccurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the within 2 To the comple	Ň	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	e Practioner: To the best of my knowledge, death occurred at the time, date 29c. License number	e and place, and due to the cause(s) and manner as stated. 29d. Date, signed (Month, Day, Year)								
)		V144 7	2 MD AT 24389									
6	√		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, Print) Ty, Duc, I al Hospital 201E. Universit	0: 0 /: 00 - 0								
	Sta	e	31. Date filed (Month, Day, Year)	32. Jegistrar's Signatury	y I hay ; Dalling 1 10 21211								
	Registra	ar	SEP 1 9 20	11 Jours B. garte									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** NORMA LEE CONSTANT 09 9:55 PM 14 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arundel Futurecare Chesapeake Arnold Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 0 9 0 9 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F Yrs. 215 30 7034 78 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 U.S.A. 106 Mariner Court Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas E. Ginneman Jessie A. Groves ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21012 James Constant - Husband 106 Mariner Ct. Arnold, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any injury or of 1. Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD Glen Haven Mem Pk 9/19/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home, PA 160 Riviera Drive Pasadena, MD 21122 21. Signature of Euneral Service Licensee 169 Riviera Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (of as a consequence of) P.O. Box 68760, Physician/Medical as been signed by the attending I should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Lectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? 1 ☐Yes 2 No certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To after death. Director: After this in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral [completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the I the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DS 3111 MD

2 m

State Registrar

DHMH 17 Rev 1/2001

2007 TIDELATER COLONGIA, ANNIAPOLIS, MD 21401

and address of person who completed cause of death (Item 23a) (Type, Print)

DAMS

TRAN

Day, Year)

mD

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 20 29731 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:03p Month Karin Grace Evans '13 September Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6601 Bowman Hill Drive Baltimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, 219-52-2668 1 🗆 M 2 🔀 F 62 **Director** Nov. 30 1948 MD Usual Residence of Deceden or 28a-f show notified at 10a. State with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number ō 10f. Zip Code Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or items 23a or lury or other traumatic event, the Medical Examiner must be 1 Funeral 21207 6601 Bowman Hill Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) U.S. Government secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Louise Tramblay Joseph E. Kohlman Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce, James A. Evans (spouse) 6601 Bowman Hill Dr., Baltimore, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, 9-19-11 Baltimore, MD Woodlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Dauge Haight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ A-teriosclenati disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi). burial-transi or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No jo Year Pregnant at time of death signed by the at d be detached for 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sclenosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗓 No 25. Was case referred to medical funeral director, Be examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 KResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural work 5 Pending injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to and title of certifier 866 who completed cause of death (Item 23a) (Type, Print) 6 TRIMBLE HILL CT LUTHERVILLE MD 21093 MD MILLTEL 62. Registrar's Sign State

Registrar

DHMH 17 Rev 06-2011

103

N

09/13/2011

KARIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Christine Fotos September 2011 8:14 AM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Heart Homes at Bayridge Anne Arundel Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct 7, 1927 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F West Virginia 83 235-40-0565 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 21401 10e. Street and Number 28 Thompson St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 No Black White, etc. 1 ☐Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 □Yes 2 No 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline Triantaphylopoulos John B. Contos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Thompson St; Annapolis, MD 21401 Alexandra Fotos - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🖾 Donation 5 ☐ Other (Specify) Funeral Ser in Ronal d 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complice shock, or heart failure. List only one he that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final disease or condition resulting in death) 1eons mentio Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ↑ 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No COY 1 🗆 Yes Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 217 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death

Examiner The law requires that the death certificate be executed and burial-tran P.O. Box 68760. attending physician for use as the buria signed by the a Division of Vital Records, has this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician

/Medical

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed

Be

ပ

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wordon Event, and the notified at once.

Baltimore, Maryland 21215-0036

/Medical

Physician/Medical ≥ Completed Be Certification: To

Medical

Examiner

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who

Sbinson Road

State Registrar 5 Pending investigation

6 ☐ Could not be

determined

2 Accident

3 Suicide

4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3:35 AM 3,201 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death Hoint If Under 1 Year I f Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 10 9. Birthplace (State or Foreign Days GEORGIA 1 **X** M 2 □ F Months Hours 82 367-32-1542 1929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 💢 No **EDGEWOOD** HARFORD CO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21040 1800 HARBINGER TRAIL . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2XXMarried 1 ☐ Yes 2 XXNo Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT ACTIVITY LOGISTICE DIRECTOR 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Msry Semore Reese Gallimore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1800 Harbinger Trail, Edgewood, Md., 21040

09/22/11

Date

WM C. BROWN FCOMM FUNERAL HOME- HARFORD, 321 S. PHILA. BLVD, ABERDEEN, MD., 2100

PHILA. BLVD, ABERDEEN, MD., 21001

20c. Location - City or Town, State

OWINGS MILLS, MARYLAND

Year

ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 and Mental Hygie is marked other be and 2 should b Health and Mer tem 27 is mark or other tem permit. Page 1 a
Department of H
Important: If ite injury any

Physician/

Medical

Examiner

Funeral

Director

State Registrar

10a. State

MARYLAND

11. Marital Status

Odessa Gallimore/Wife

4 Donation 5 Other (Specify)

1XXBurial 2 Cremation 3 Removal from State

20a. Method of Disposition

21. Signature of Fun

Director

Funeral

þ

Completed

Be

2

Physician/ Medical Examiner

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit Physician/Medical by Completed Be မ Certificate:

P.O.

Division of Vital Records,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Prostate Caremana Metast resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Due to (or as a consequence of resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred **X**Natural (Month, Day, 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

**Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Framiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

40054439

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

State Registrar

Medical

29a. Certifier

(Check

only one 29b. Signa

Vincent & gime was Do 31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2011

VA Maryland Health Care System, Pera 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No.2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Physician/ 2011 09:50 M September ELOUISE Т GRIFFIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A GOOD SAMARITAN HOSPITAL BALTIMORE 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral Min. FEB 23 Days 1 🗆 M 2 💢 🛣 ^{ear}192<u>5</u> MARYLAND Director 86 218-18-6974 Usual Residence of Decedent 10d Inside City Limits shov 10a. State 10b. County 10c. City, Town or Location with the Maryland Director or 28a-f sh notified a 1 X Yes 2 No MARYLAND N/A BALTIMORE 10g, Citizen of What Country? 10e. Street and Number "natural", or items 23a o Funeral U.S.A. 21218 2623 ROBB STREET within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2XXNo Specify. Specify: BLACK Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than aumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) FAMILY CARE HOUSEWIFE 12vrs 2vrs Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည HALLORAH REED MORRELL WASHINGTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troonee. Maryland 21244 Michele D. Travers/Daughter Gartside Ave., Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/21/11 OWINGS MILLS, MARYLAND GARRISON FOREST WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVE., BALTIMORE, MARYLAND 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death 4 ☐ Pregnam 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Wonknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy autopsy performed? 2 No 1 Yes 2 W Yes 2 : After this certifica e funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗆 Yes 2 40 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner PDeath 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending injury within 24 hours are: _____ To the Funeral Director: After ______ After ______ To the Funeral Director and the fur Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and six 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) de Parkville,MD-21234 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2011 Registrar

DHMH 17 Rev 7/2009

		Please	State of Marylar				-	•	ible.		
		for State Registrar	State of Marylar		inent of th			Reg. No 2 N	11 20	1725	
Physic		1. Decedent's Name (First, Middle, Las	un can Green		10010 0. 2		2. Date of Dea Month Septem	th Day	Year 3. Time	e of Death	
Med Exam		4a. Facility Name (if not institution give	street and number)	41	b. City, Town, or Rand	alktou	1	4c. County	of Peath	e	
Funera	Г	5. Social Security Number 6. Se	7. Age (In yrs. I	ast birthday) I	f Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	, Year)	9. Birthplace (Sta Country)	te or Foreign	
Directo ≧	٦.	Usual Residence of Decedent	□ M 2 1 5 4	Yrs.			104-01	-1957	AL		
vith the Maryland 23a or 28a-f show st be notified at	rector	10a. State 10b. County Baltin	1 /	y, Town or Location		n				e City Limits Yes 2 No	
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene. I other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 9003 Meadou	Heights	Road	10f. Zip Code	33		10g. Citizen of V		E	
death r items		11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was	Decedent of His	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - American Indian k, White, etc.	,	
21215-0036 within 72 hours after death with giene. ter than "natural", or items 23, the Medical Examiner must.	ed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1 🗆	Yes 2 No	Specify:		Specify:	Black		
Ind 21215-0 is filed within 72 hour tal Hygiene. ex other than "natus event, the Medical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent	t's Usual Occupa d of work done d IOT use retired)	ation uring most of wor	king	16b. Kind of Bu	usiness/Industry		
212 within giene.		Elementary/Secondary (0-12)	Callege (1-4 or 5+)	Cost	1	ountar		Acc	ountir	19	
	To Be	17. Father's Name (First, Middle, Last)	uncan			18. Mother's Nar	me (First, Midale,)		
ire, Maryland 1 and 2 should be filed of Health and Mental Hy item 27 is marked oth		18a Informant's Name/Relationship (Ty Cliffon M. Gree	pe, Print)	1/- 1	Address (Street a		ral Route Number	City or Town, S	tate, Zip Code)	リ コルナ	
1 and 1 item		20a. Method of Disposition 1 Burial 2 Cremation 3	20b. F	Place of Disposition	on (Name of	1	Date	20c. Location -	City or Town, State		
timent tant:		4 Donation 5 Other (Specify) K	ina Me	emoria	J 19-6	20-11	Winds	DC Mill	m	
Ball permit Depar Impor any in		21. Signature of Funeral Service Licens	Liene	87	28 216	erty R	ad, Ro	ndalls	town M.	D 21133	
1.00		23a. Part 1. Enter the disease, or companies shock, or heart failure. List only of	est,	Approxi Interval							
Ph_sician Medica		Immediate Cause (Final disease or condition resulting in death)	a. Ovan'an (a Due to (or as a conseq						Oliseta	id beatif	
Examine		Sequentially list conditions,	b								
rted J ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):							
be executed ician and burial-transit	cal Ex	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
	ledic	d									
Box 6876(death certificate he attending physed for use as the	Physician/Medi	230. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta	al death 3 🗌 E		у		1	23d. Date of delivery Month Day Year		
he deat y the at iched fc	hysic	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown	death 5 □ 0	ther (specify)			IMO	nth Day	rear	
ision of Vital Records, P.O. Box 6876C Attending Physician: The law requires that the death certificate has been signed by the attending physe the funeral director, page 2 should be detached for use as the	ğ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the unde	erlying cause giv	en in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
Division of Vital Records, ital or Attending Physician: The law requires staffer death. In Director, After this certificate has been signed in by the funeral director, page 2 should be	Completed						24a. Was	an 24b. \	Nere autopsy findin	gs available	
Vital Reco sician: The law i certificate has b	Com						autop perfo 1 Yes	rmed?	orior to completion death? I ☐ Yes 2 ☐ No		
Vital ysician: s certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	LEDIO II II II	Othe	r: Che		ر المال	n-Patient Ver (Specify)	ospice	
of V ng Phys ter this	te: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at		ow injury occurr			
sion ttendir death. stor; Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 No	29f Location (9	troot and Number	er or Rural Route N	umher	
Division A state as all Direct ed in by	I Cer	4 Homicide determined	building, etc. (Specify		, lactory, office		City or Tow		or right floorer	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division of Virothe Hospital or Attending Physical Within 24 hours after death. To the Funeral Director, After this completely filled in by the funeral differential differen	Medical	(Check 2 Medical Exami	sician: To the best of my know ner: On the basis of examination	n and/or investiga	tion, in my opinio	n, death occurred	at the time, date a	nd place, and du	e to the cause(s) and	manner stated.	
To the within To the сотріє	Σ	20h Signature and title of cortifier	e Practitioner: To the best of	my knowleage, a <u>e</u>	29c License	number			d (Month, Day, Year,	-	
		MSRY UNL		00.1.7		57465					
IDV		30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type, Print	5203	Bal	more	MD Z	1009		
St. Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 9 201	Registrar's Signa	bar	2						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:02 AM GARRISON 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death WESTMINSTER CARROLL HOSPICE DONE HOUSE If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2**X** F Days Min 30 5082 Yrs Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State notified at 10d. Inside City Limits Director SYKESVILLE 1 Yes 2 No MD 10e Street and Numbe 0 10g. Citizen of What Country? ms 23a or must be r Funeral 2412 USA items death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, and Mental Hygiene. is marked other than "natural", or iter raumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🏞 No Specify: Specify: 3 ¥ Widowed 4 ☐ Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) COMEMAKER HUME 8 0 Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 artment of Health and Ment ortant: If item 27 is marke injury or other traumatic UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BONNIE SYKESVILLE MU 2170 SMITIT みりん HAIGHT AVE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place SYKESVILLE, MU 12011 JUZUMBRUNEH & MON CO 700 21784 RO ELDERSBURG, MO Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of) attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director: After this certificate has be After this certificate has funeral director, page 2 autopsy performe 2 1 No 1 Yes **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital 1 Yes 2 No INDATTER ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural 2 🗆 No ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie pleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

SOUTH CENTERST. WESTMINSTER MO 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

FLAVIO KRUTER

Date filed (Month, Day, Year,

9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stept. 11, 201 far John F. Hammill 8:00ат м Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Sykesville Transitions Health Care Social Security Number If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 □ F Months (Month, Day, Year) Country) Director 81 1929 076-22-3264 Nov. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Sykesville Carrol1 1 Xyes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21784 7426 Village Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc 1 Never Married 2 X Married Completed by Yes, Give 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 1951 - 53Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pipe Fitting Pipe Fitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Karrigan John F. Hammill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7426 Village Road Sykesville, MD 21784 Mrs. Carol Anne Hammill (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State All County Cremation 9/17/2011 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 41 MDPO Box 195 Sykesville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medica resulting in death) Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (o as/ consequence of) Exami ed by the attending physician and detached for use as the burial-transit executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 No Unknown Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 2 No 3 Probably Certificate: To Be Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Funeral Director: After this certificate of completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referr medical 26. Place of Death (Check only one) examiner? 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Ursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred atural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

1)oshur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Charles Richard Hammonds 5:45 P September Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore 3311 Ailsa Avenue 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days March 15,1937 Months Hours Maryland 1**X** M 2 □ F 213-34-6459 **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Yes 2 No Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Funeral 21214 3311 Ailsa Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1X Yes 2 □ No 1 X Never Married 2 Married 2 Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK Elizabeth Engelmann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3306 Ailsa Avenue, Baltimore, Maryland 21214 Laura Tote Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-10-11 Hanover, Maryland Ardent Cremation, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ear Nine. Interval Between Onset and Death Immediate Cause (Final Physician/ Mansh disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underl, in Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death Month Day in the past 12 months? for Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 🖟 Residence 6 ☐ Other (Specify) 은 1 Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident injury 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Koertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the cases of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nymber Practifiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title o

State Registrar 9512 HARFORD ROAD SUITE 4 BALTIMORE, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UR MoHAMMAD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ tarris 201 berta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bartmone Raltimore Hospital SAINT ALINES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Qate of Birth Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** Month, Day 8 ear 916 Days 1 M 2 Y 213-70-015 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No WYMM 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 207 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 -100 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) omesti omestic Be 18. Mother's Name (First Middle, Maiden Surname) ဂ္ Held lones 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Suzy Landington-Ave Gwynn Odc. ornish 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Woodlawn, mD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final piratur Physician/ UHP disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Seps: Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Aspiration Presmonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 € 25. Was case referred to medical 26. Place of Death (Check only one) Vital Hospital or Attending Physician: Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 - No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of injury 28c. Injury at work? 1 ☐ Yes Division of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

— Certifying Nurse Practioner 1. It is cost of my thousand a certifying Nurse Practioner 1. It is cost of my thousand a certifying Nurse Practioner 1. It is cost of my thousand a certifying Nurse Practioner 1. It is cost of my thousand a certifying Nurse Practioner 1. It is cost of my thousand a certifying Nurse Practioner 1. It is cost of my thousand a certification and does and does not due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Year) Registrar

RFR

I

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend #9 Per ANA BD G919 9/20/2011 Jh State of Maryland / Department of Health and Mental Hygiene

			Ce	ertificate of Death	Reg. No. U 29/40
			1. Decedent's Name (First, Middle, Last)	2. Det Mo	te of Deeth 3. Time of Death
	Physicia		Tony Howkins		23 11 1.40 pm
1	/Medic Examin		4a Facility Name (If not institution, give street end number)	4b. City, Town, or Location of	of Deeth 4c. County of Deeth
			Hamilton Genesis	Butiness	- 15 Himse City
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthde)	Months Days Hours Min. 8. Date Months Days Hours Min.	te of Birth 9. Birthplace (State or Foreign Country)
ы	Director		C18-110-28.D	./-	- ZO- 60 Maryland
	pue M	-	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or L	Location	10d. Inside City Limits
	danyi daho	ō	MD Baltimo	re	1∭ Yes 2□ No
	288	2	10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
	3a o	Funeral Director	1218 N. Eden St.	21213	USA
	death	ner	11. Merital Stetus 12. Was Decedent Ever in U,S. 13	B. Was Decedent of Hispanic Origin? (Specify Year of Year, Specify Cuban, Mexican, Puerto Rican,	es or No- etc.) 14. Race - American Indian, Black, White, etc.
9	or its		1 Never Married 2 Married 1 Yes 2 → No	1 ☐ Yes 2 No Specify:	Specify: black
903	filled within 72 hours efter death with the Marylend Hygiene. ther than "natural", or frems 23s or 28s-f show ther than "natural Examiner must be noritized at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	edent's Usual Occupation	16b. Kind of Business/Industry unk
<u>7</u>	nath edica	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv	ve kind of work done during most of working . DO NOT use retired)	
12	withii 9ne. than		Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Se	ecurity	
d 2	Hygi Hygi other	Ö	17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First,	, Middle, Maiden Surname) unk
lan	ld be lentel ked c	To Be	Edward Hawkins		
Maryland 21215-0036	shou and M armar urmert	-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	illing Address (Street and Number or Rurel Rout	te Number, City or Town, State, Zip Code)
Ξ	and 2 alth e		Tidilbett beams	924 E. Coldspring Ln;	
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours efter death with the Marylen Department of Health end Mentel Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Important: If Item 27 Is marked other than "hatural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of Date rematory or other place)	e 20c. Location - City or Town, State
<u>E</u>	Pagnent: If		4 □ Donation 5 🛛 Other (Specify) in state		A to a Brand
alt	Departr Importu any Inj		21. Sign ture of Funtral Service Conserved, Director	22. Name and Address of Facility State	; Baltimore, MD 21201
ш	20529		Sent // les		
			23a. Pert1. Enter the disease, or complications that caused the death. Do not e shock, ok heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or resp	oiratory arrest, Approximate Interval Between Onset end Death
	Physician		0.10		
	/Medical		Immediate Ceuse (Final disease or condition resulting in deeth)		
		-	Due to (or as a cons	sequence of):	1
	uted ansit	edical Examiner	Sequentially list conditions b. Due to (or es a cons	sequence of):	
ć	exection and the street of the	Exa	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury		1
68760,	death certificate be executed e attanding physician end ed for use es the bunel-trensit	cai	Cause (Disease or injury that initiated events pue to (or as a cons resulting in death) Last	equence of):	
	ng ph	5			
Вох	ith ce tandi	lan	d		1
	a dea the at hed fo	sici	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
P.0	d by t	된			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
3,	v requiras thet tha death cer been signed by the attandir should be detached for use	Completed by Physician/		-	24a. Was en autopsy 24b. Were eutopsy findings
Ö	requ	ete			performed? available prior to completion of ceuse of deeth?
Records,	hes b	m			1 Yes 2 No 1 Yes 2 No
al	i: The icate h			26. Place of Death (Che	
Vital	Physician: The law this certificate hes ral diractor, page 2	o Be		Other: /	5 ☐ Residence 6 ☐ Other (Specify)
ō	Phys r this sral di	7: To	Los Data Alaires Con Time	e of 28c. Injury at 28d. I	Describe how injury occurred
on	ding th. : Afte e fune	tion	1 ↑ ☐ Naturel 5 ☐ Pending (Month, Dey Yeer) Injured 2 ☐ Accident investigation	M 1 Yes 2 No	
Division	Atter r dea octor by the	HCE	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)
ă	s afte	Certification:	Sulluing, etc. (opoury)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edical (29a. Certifier (Check only (C	eath occurred at the time, date end place, and d r investigation, in my opinion, death occurred et	due to the ceuse(s) and manner as stated. The time, date and place, end due to the cause(s)
	the H hin 24 the F	Aedi	one) and manner steted.	29c. License number	29d. Date signed (Month, Dey, Yeer)
	75 Vill 50 Pio	Σ	29b. Signature end title of certifier	DADT DOT	07/20/11
			(1).17	DUV IV	
			30. Name and address of person who completed cause of death (Item 29e) (Tyl	Pl. Parkeiler r	MD-21254
		to	31. Date filed (Month, Dey, Year) 32: Registrer's Signature		
	Sta Registr		CED 1 9 2011 A. A. A. Lace	Kel	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 2011 6:20 Physician/ 28 P_M Bette Harmon Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F **Director** -40 Maryland 217-40-674 Usual Residence of Dece 74 Nov 17, 1936 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Essex Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21221 1000 Franklin Ave #1105 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after death 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hyglene ant. If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Bendix Corporation assemblyman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Ersky Newlon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 322 Timber Grove Rd; Reisterstown, MD 21136 Betty Joan Muniz - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or other 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Rona I d rector 655 W. Baltimore St; Baltimore, MD 21201 23a. Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a con a quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an ate has b autonsv perforn death? 1 Tes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Tes this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 \square Pending work 1 Yes 2 No n 24 hours after death.

e Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only on 29d. Date signed (Month, Day, Year) ure and tith 29b. Signa

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

751

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 25, per me 9920 10-25-11 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANE LANTZ Month FNNY sepr Medical 01 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death eumbi CaH towa Social Security Numbe 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Days 1 M 2 X F Months Hours Min Maryland **Director** ใช56 216-66-2054 55 Jan. Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 10580 Cross Fox Lane, Unit E-1 21044 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 5+ teacher public school Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James C. Lantz, Sr. Betty Wetzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Lantz Jr./ brother 643 Raywell Ave. Union Bridge, MD 21791 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 9/19/2011 Mountain View Cem. Union Bridge, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility Hartzler Funeral Home E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and CERTIFICATION APPROVED BY MEDI Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 4 Pregnant at time of death 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed peen y perlipsidering 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mychel mD 16 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUMERA MUTAMO HCAH 31. Date filed (Month, Day, Year) egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Medical Mil ton 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death HUSA-1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours (Month, Day, 218-07-3163 **Director** 91 Maryland (Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Examiner must be notified 1 Yes 2 X No Maryland Baltimore Randallstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral 3114 Offutt Road with 21133 USA death v items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 'n, þ 1 Never Married 2 X Married be filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: "natural", WWII Specify: White 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 House Painter Residential/Commercial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ပ Orval R. Mann Elizabeth E. Addleman other traumatic Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Elizabeth K. Mann/wife 3114 Offutt Road Randallstown, MD 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation Service 9/15/2011 Sykesville, MD 21. Signature of Funeral Service Licens Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, MD 2 auna mo Þ (410-795-1400)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Seps Medical resulting in death) Due to (or as a consequence of): Examiner Pertuct-u Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or impury that initiated events resulting in death) Last Com Caleand Due to (or as a consequence of) attending physician for use as the burial Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 s autopsy performed Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 1 ☐ Yes 2 Z No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🗌 By Ber of only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Signature

31. Date filed (Month, Day, Year) SEP 1 9 2011

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ BEVERLY JOAN MONAGHAN Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Arundel Glen Burnie Anne Baltimore Washington Medical Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 5. Social Security Number Age (In vrs. last birthday) **Funeral** 04 1 5° 1931 80 217 62 9938 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 10a. State 10b. County important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Anne Arundel Pasadena MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral 21122 U.S.A. 7816 Outing Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc 1 Never Married 2 Married þ ☐ Yes 1 ☐ Yes 2 X No Specify: If Yes, Give White Completed 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 6 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) ည Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Pasadena, MD 7816 Outing Ave Marguerite Lange - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9/21/11 Glen Burnie, 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 21. Signature of Funer ervice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a conseduence of ir any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year page 2 should be detached for Day Other (specify) Pregnant at time of death the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Certificate: To Be examiner? Hospital ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Dea h 28b. Time of 28d. Describe how injury occurred Natural 5 🗆 Pending 2 🗌 No Investigation Accident Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗘 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier rson who completed cause of death (Item 23a) (Type, Print) 30. Name and addr

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 19b per fb g919 9-19-11 yt State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:40 September 2011 Medical 4c. County of Death a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 49ne timore If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 M 2 DF Days Hours Min Director 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number Funeral items 23a death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural", 3 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT yes retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumoth. College (1-4 or 5+) econday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3240 Westmont Ave. Baltimore, Md. 21216 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ANS DOWN 4 ☐ Donation / D ☐ Other (Specify) 21. Signature of Ameral Service Lice 22. Name and Address of Facility WARK! 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ 4 cute bour Medical resulting in death) Due to (or as a consequence of): Examiner reumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine burial-transit pronic and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) cate has been signed by the cage 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 M No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 V director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ျှ 1 Inpatient 2 KER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes inserted filled in by the funeral Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Enternst

DHMH 17 Rev 7/2009

State Registrar

John

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Margie Gill Muse 5:50P M 2011 Sept 15 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Lutheran Village Westminster 9. Birthplace (State or Foreign MD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1-30-1926 Hours 1 🗆 M 2X 🗆 F Min 214-20-8674 85 Director Usual Residence of Decedent 28a-f show 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Carroll Westminster 1 Yes 2 XNo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 505 High Acre Dr., Apt. 203 21157 USA items ; permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: white 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl Gill Ida Yingling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Muse-son 1511 N. Main St., Hampstead, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) South Carroll Crem 9-16-11 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home lother III Kemas 1. ,Westminster,MD 21157 Main St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Cancer Physician/ Suspected disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any lating time all cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) signed by the attending physician be detached for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed 24 hours after death.

Funeral Director: After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 within 2 To the F 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) censwaya, M

Registrar

DHMH 17 Rev 7/2009

State

DR.

Westminster

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PAN GIIRIYA 349 Malww

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 20T1 3:38 Dinah Fay Moore Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days 1 □ M 2 🗓 F Hours March Day Year) 1958 DeTaware 53 Director 217-70-2209 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s dical Examiner must be notified 1 🗆 Yes 2 No Hyattsville MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20782 USA 4922 LaSalle Rd. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. Completed by 1 X Never Married 2 Married Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha unk education tink teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked o t. Page 1 and 2 should be fil tment of Health and Mental tant: If item 27 is marked Robert Carl Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3127 Cliffmont Ave; Baltimore, MD 21213 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Robert Moore - son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 22. Name and Address of Facility State Anatomy Board Signature of Euneral Service Lice 17 655 W. Baltimore St; Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between nset and Death Immediate Cause (Final Pnysician/ Arteriosclandoc LEANS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Year Month Yes 2 No ed by the a 1 L Yes 2 L 9 Unknown 9 Unknown P.O. 1 been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Usesity Hypoventilation Syndrome 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? Supermontid Obesty Amemightial Fibrillation 24a. Was an page 2 Respiratory Frilow/ Ventilator Dependent performed?

1 Yes 2 No or Attending Physician; The 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No မ 1 Inpatient 2 SER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) tor: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the 29b. Signature and title of certifier 29c. License number

State

Registrar SEP 1 9

31. Date filed (Month, Day, Year)

allere ho

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201852

September 11, 2011

Hyatk will Mis 20749

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 520 a Medical 4c. County of Death 4a. Facility Name (if not institution, give street and no 4b. City, Town, or Location of Death Examiner Baltimore Greneral Hospital If Under 1 Year If Under 24 Hrs. Date of Birth 9. Bjrthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 1 M 2 D F Months Hours Min (Month, Day, Ye CAColina **Director** Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified 1 Yes 2 □ No NA AHIMORE And 10f. Zip Code ō 10e Street and Number 10g. Citizen of What Country? items 23a or ner must be Funeral (15A 21223 W 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iter Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced YICAN er than "natur the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 16/8 17 is marked other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traconce, MURC 345 laware. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) netro BAHIMOLE 22. Name and Address of Facility Aney m. WAllace 2405 (W. FRANKIA) 21. Si mature of Funeral Service Lice see Funer W. FRANKlin Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heald failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition) Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as a consequence of attending physician and for use as the burial-tran-Due to (or as a consequence of resulting in death) Last Physician/Medical The law requires that the death certificate be IE EEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ page 2 should be detached for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy erformed? death? Yes 2 ☐ No 2 🖪 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Director: After this certificate has To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifies completed filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

State Registrar

Medical

29a. Certifier (Check

only one)

Certifying Nurse Praction

9

who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 9/9/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4b. City Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 00 monta 9: Birthplace (State or Country) unk If Under 24 Hrs If Under 1 Year 8. Date of Birt . Age (In yrs. last birthday) **Funeral** Days Min **Director** Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Examiner must be notified Cabin John 1 🗆 Yes 2 🔀 No MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20818 USA 23a Funeral 6514 76th Street items death 11. Marital Status unk 12. Was Decedent Ever in U.S Armed Forces? unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes 2 🗆 No within 72 hours after Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify 3 Divorced Year or Dates traumatic event, the Medical unk Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, til Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6001 Muncaster Mill Rd; Rockville, Maryland 20855 Casey House 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in State cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Poard Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part L. Enter the disease, or conshock, or heart failure. List only is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ano disease or condition Medical resulting in death) consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): physician s the burial Physician/Medical P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ the atter in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been signage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospita Other: 2 No ᅆ 1 Yes 1 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence After this 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on Signat 29b. re and title lame and address of person who completed cause of death (Item 23a) (Type, Print) A

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	Department of	of Health and	l Mental Hyg	giene				
			T State Registrar	Certificate of	of Death	F	Reg. No.2				
	Physicia	in/	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day Year	3. Time of Death			
	Medi	cal	Charles Powell			07	15 2011	1200 AM			
	Examir	ier	4a. Facility Name (if not institution, give street and number) FRANKFORD NURSINES REPAR	4b. City, Jow	n, or Location of Dea	ath	4c. County of Death	1			
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last b	pirthday) If Under 1 Y	ear If Under 24 Hi	rs. 8. Date of Birth	N/A	nplace (State or Foreign			
	Director		218-09-4298 1™2□F 94		ays Hours Mi		Year) 1916 MA	RYLAND			
-	, MC		Usual Residence of Decedent								
	yland f she ed at	흕	10a. State 10b. County 10c. City, To	own or Location				10d. Inside City Limits			
	e Ma r 28a notifi	Director	MARYLAND N/A 10e. Street and Number		BALTIMORE		1X Yes 2 □ No				
	ith th	ᇛ		10f. Zip Co			10g. Citizen of What Country?				
	ems arm	Funeral	3633 KENYON AVENUE 11. Marital Status 12. Was Decedent Ever in U.S.		213 of Hispanic Origin? (Specify Yes or No-	U.S.A. pecify Yes or No- 14. Race - American In				
9	or ite	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Yes, specify (Suban, Mexican, Pue	erto Rican, etc.)	Black, White				
ဗ္ဗ	flied within 72 hours after death with the Maryland al Hygiene and the stran "natural", or items 23a or 28a-f sho dother than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	ed	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 □ Yes 2 🛚	No Specify:		Specify: BLA	CK			
-	2 hou "nati	Completed	15. Decedent's Education 16 (Specify only highest grade completed)	oa. Decedent's Usual Oc (Give kind of work do	cupation	orkina	16b. Kind of Business In	ndustry			
2	thin 7	, mo	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use reti	red)		DEAMU O	ADE			
2	ed wi Hygie other ent, ti	Be (12yrs 17. Father's Name (First, Middle, Last)	MORTICIA		ame (First, Middle, I	DEATH C	AKE			
Maryland 21215-0036	be fill ental ked c	2	JAMES H. POWELL			ZABETH GR					
ar∠	2 should be flied within 72 hours after death with the Maryland thand Mental Hygiene. 77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at			9b. Mailing Address (Str			City or Town, State, Zip	Code)			
	d 2 si alith a n 27 i ertra		·				Maryland 21	, i			
ore	ige 1 and 2 s nt of Health t: If item 27 or other tr		20a. Method of Disposition 20b. Place 20b. Place ceme	of Disposition (Name or	nlace)	Date	20c. Location - City or T	own, State			
Ĕ	Page 1 ment of tant: If it lury or o			ISON FOREST	· · · · · ·	/23/11	OWINGS MILL	S, MARYLAND			
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Fun at Leave e	WILLIAM	dress of Eacility C BROWN CO	OMMUNITY	FUNERAL HOM IMORE, MD 2	E P.A.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.					Approximate			
P	hysician/			DEMENE	A		J.	Interval Between Onset and Death			
	Medical xaminer		resulting in death) a. Due to (or as a consequence		,						
	Xammer	r.	Sequentially list conditions, b.								
	sit sit	Examiner	if any leading to introdicts cause. Enter Underlying Cause (Disease or injury	6-0f):							
	cate be executed physician and sthe burial-transit	Exa	that initiated events resulting in death) Last C	e of):							
5	siciar buria	dical									
	g phy as the	w 1	_ u								
20 3	endin use	an/h	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal dec	eth 3 🗆 Ectopic pregu	nancy		23d. Date of deli-	very			
Š i	dearr he att ed for	Physician/M	1 Yes 2 No 4 Pregnant at time of death				Month	Day Year			
5	Autonomy Priystolan: The law requires that the death certific ecfor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as		9 Unknown Part II. Other significant conditions contributing to death but not resulting	g in the underlying cours	agivon in Part I	00. 5:14.1					
,	signe	a p		y in the drawing odds	s giveri ii i arei.		bacco use contribute to the second se				
cords,	reduli	ete									
ວ [e law e has ge 2 s	Completed				24a. Was a autops perfor	sy prior to co	opsy findings available ompletion of cause of			
ב ו =	ificate or, pa		25. Was case referred to medical	24	i. Place of Death (Ch	1 Tyes		2 No			
VILA	ysicia s cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C		Othor	· · · · · · · · · · · · · · · · · · ·	ence 6 Other (Specif	5.4			
5 5	ig rin ter thi neral			. Time of 28c. I	njury at vork?		w injury occurred	<i>y</i> /			
	eath. or: Af	ifica	2 Accident Investigation 3 Suicide 6 Could not be		Yes 2 No						
7 7	after death. Director: After this I in by the funeral di	Certificate:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, offi	ce	28f. Location (St City or Town	reet and Number or Rura n, State)	al Route Number,			
<u>.</u>	hours and meral of filled	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occured at the f	ime, date and place,	and due to the cau	se(s) and manner as stat	ed.			
1	To the hospital or Attending Priystoats. The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as		(Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practioner: To the best of my known 29b. Signature and title of certifier	wledge, death occurred a	t the time, date and p	place, and due to the	cause(s) and manner as s	tated.			
,	8 4 8		Heronicas Hella 1- Dal	- Chap P	158140	2	9d. Date signed (Month,	Day, Year)			
	21/8		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		101	10-11	113			
) Stat		31. Date filed (Month, Day, Year)	OID WAIL	AN Wood	5 KA £ 3.0	4 MBMU.	12,40			
	Registra	-	SEP 1 9 2011 General . Jane	5							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#5perfn g919 9-30-11 d.o. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 9 Day 07 Physician/ Year 0553 AM 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimor of Mary land Medical Center 21945444609 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Off Off **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 🗆 F Months Days Hours 219 54 61 760 **Director** MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Examiner must be notified at Director MD Anne Arundel Pasadena 1 Tes 2 No 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8473 Meadow Lane 21122 U.S.A. . Page 1 and 2 should be filed within 72 hours after death viment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Self Employed Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Robert Carl Snyder Marjorie Ann Salmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8473 Meadow Lane Pasadena, MD 21122 Rosemary Snyder - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk aven Mem Pk: 7/14/11 22. Name and Address of Facility GJ Gonce Funeral Home, PA 9/14/11 Glen Burnie, 21. Signature of Euneral Sevice Itensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician/ Medical Due to (1 r as a consequence of): Examiner IMONI Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last lymphoma Due to (or as a consequence of attending physician Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ be detached for in the past 12 months? Month Year Pregnant at time of death Day Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, -ung Disease 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should Mycobacterium 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an (oryplex certificate has autopsy performed' 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending death. 2 Accident Investigation 1 ☐ Yes 2 ☐ No i 24 hours after deat e Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the lewithin 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 5 64 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2011 Registrar

P.0. Division of Vital Records.

				Plea	-	-								II Copie		_	ible.			
		State of Maryland / Department of Heading State 1 - State Registrar State of Maryland / Department of Heading State of Department of Heading State of Maryland / Department / Depart												nemai i	Reg. N	0.0	111	-	207	E 2
			Decedent's Nam	e (First, Middle	e, Last)									2. Date of Death				3.	Time of D	eath
Phys /Me	icia dica		Doreen Carol Sutton											Month Augus			Year 11	1:	34 A	м
Exa			4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death							y of Deatl			
				Asbury		ce				Denton						Caro				
Fune			5. Social Security N		6. Sex	M 2 ∏ F	7. Age		last birthday) Yrs.	Month:	er 1 Year Days	Hours Hours	Min.	8. Date of E (Month, I Nov 5	Birth Day, Year 1 O /	()	Co.	untry)	(State or F erse	-
Direct	or	-	138-34- Usual Residence of				<u> </u>	70						NOV J	1 2 -	+0	146	w J	erse.	у
yland	EE .	Ì	10a. State	10b. County				10c. Cit	y, Town or Lo	cation						10d.				Limits
e Mar a-fsl		້ອ	MD	Car	olin	.e		D	enton									1	☐Yes 2	ĽχΝο
iff the	:	e l	10e. Street and Nur		Das					10f. Zip Code 21629						itizen of JSA	What Co	untry?		
If a list in 15-0050 filed within 72 hours after death with the Maryland Hygene. other then "natural", or items 23a or 28a-f show ent. It is Miglial Exert in control or the mount in the mount in the mount in the mount of the mount in the mount of the mount in the mount of the m	8	Funeral Director	24160 A																	
er de items	١.	Ä,	 Marital Status Never Marr 	: O		2. Was Ded Armed F 1 ∐Yes	cedent E orces?	Ever in U.	S. 13.	Was Dec If Yes, sp	edent of H ecify Cuba	ispanic O an, Mexica	rigin? (Sp in, Puerto	ecify Yes or N Rican, etc.)	No-	Bia	ce - Ame ick, White	e, etc.	Jian,	
oours aft		2	3 X Widowed			If Yes, G	aive	WO .		1 □Yes	2 X] No	Specify	<i>'</i> :			Speci	_{fy:} wh	ite		
2 hou		Ted	(0	15. Deceden	t's Educa	ition	0		16a. Dece	dent's Us	ual Occup	ation			16b.	Kind of E	Business/I	Industry		
Lithin 7 thin 7 the and "n	1	Completed	Elementary/Seco	cify only highe: ondary (0-12)	st grade (College		+>			rork done d use retired	auring mo d)	st of work	ing						
ed wii lygier ly. In			12				4		di	cecto	or ——			(E)			ın re	sou	rces	
be fill be fill be fill be fill be fill be fill be fill be fill be better bette	- 0	n n	17. Father's Name William			rton								_{e (First, Midd} ean Pa		n Surnai	me)			
Itally Itality 4.14.15-0050 2 should be filed within 72 hours after death wire and Mental Hyglene. Is marked other than "natural", or items 23a araumatic event, its Medical East.	1	2	19a. Informant's N						10h Maili							or Town	State 7	Zin Code	2)	
ite, INTAILY INTAILY ZIZIOUOOO s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. titem 22 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It is Model Exercises, just be notified.				Sutton					405	ailing Address <i>(Street and Number or Rural Route Number, C</i> 055 Heaps School Rd; Pylesvi						.11e, MD 21132				
Dallinoie, IV permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr			20a. Method of Dis	•				20b. F	Place of Dispo cemetery, crei	sition (Na	ame of other plac	e)	1	Date	20c.	Location	- City or	Town, S	itate	
Pages 1 Tent of B ant: If ite			1 ☐ Burial 2 │ 4 ሺ Donation			moval from	n State		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	, , , , , , , , , , , , , , , , , , , ,	·								
Dalti permit. Departm Importa	once.		21. Signature of Fu	neral Service	Licensee	del.	Dir	ecto	r 22					ite Ana				010	0.1	
4 ao = 8	Ö		XIII	1/10	11				- 12		111 11			St; Ba		nore:	, MD			
		Į	shoom or hea	the disease, or art failure. List	only one	cause on	each lin	the death	h. Do not en	ter the m	ode of dyin	ng, such a	s cardiac	or respiratory	arrest,			Inter	roximate rval Betwe et and De	een ath
Physicia /Medic		1	Immediate Cause disease or condition resulting in death)	on	_ a.	0	Var	10	ri c	M	ICE	<i>y</i>					<u></u>	Dycc	1156	monti
Examin						Due to	o (or as	a consequ	uence of):									•		
		9	Sequentially list configured in the sequential sequence of the	nditions, mediate	b.	Due to	o (or as	a consequ	uence of):											
cutec nd ransit		Examiner	mai initialeu events	5	c.															
be executed ician and ourial-transit			resulting in death)	_ast		Due to	oras	a consequ	uence of):											
	- 4	riiysiciali/iwedical			d.															
eath certific attending p for use as I	28.6	Me	IF FEMALE:		230	c. If yes, or	utcome	of pregna	ancv							334 D	ate of del	harv		
leath atter		200	23b. Was deceden in the past 12 1 ☐ Yes 2 [months?		1 🔲 Live	birth	2 Feta	I déath 3[Ectopic Other (pregnanc	у					lonth	Day	Ye	ar
The law requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the		2	9 Unknown			9 ☐ Unk	nown										_			
s tha gned		Ç.	Part II. Other signif	licant condition	ons contr	ributing to	death bu	ut not resi	ulting in the u	nderlying	cause give	en in Part	l.	23e. Did		5.4	ntribute to	the car	use of dea	ath?
w requires to be a signer should be								-						1	Yes	2 No	3 □ Pr	obably	4 🔲 Un	known
e law r has be		combiered												24a. Wa	as an topsy	24b.	. Were au	topsy fi	indings av	ailable ise of
The The cate has page	- }	3												pe: 1 □ Yes	rformed?	10	death?	1	No	
iclan: The certificate ector, pag		ט ר	25. Was case refer examiner?	at a second	Но	onitol					Oth		e of Deat	h (Check only	y one)					
Phys this	115	2	1 ☐ Yes 2 ☐ 27. Manner of Deat		Ino	spital: 1 ☐ 28a. Date			ER/Outpatier 28b. Time o		OOA Othe	4 🗆 🗅	lursing Ho				ther (Spe	cify)		
iding Physician: th. After this certific	1		Natural	5 Pending		(Mo	nth, Day	(, Year)	Injury	М	Work	yai ∢? Yes 2.[INo	28d. Describ	e now inj	ury occu	rreu			
Attending Physician: r death. ector; After this certific. by the funeral director, i	9	2	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could r determ	not be	28e. Plac	e of Inju	ıry - At hç	pme, farm, str	eet, facto			_	28f. Location			ber or Ru	ıral Rot	ıte Numbi	ər,
tal or rs afte al Dire	100	ב ט	4 Homicide			build	ding, etc	:. (Specif	у)					City or I	own, Sta	ite)				
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	0.00	n l	29a. Certifier (Check only one)	2☐ Medical		er: On the		examina						, and due to the rred at the tim						
To the within To the	N		29b. Signature and	title of certifie	-	_ 4 ^				2	9c. Licens	e number			29d. E	Date sign	ed (Mont	h, Day,	Year)	
			▶ ()	H Ken	->	SVV					D.3	988	37		(9/1.	2//	1		
			30 Name and addr	ess of person	who com	pleted cau	se of de	eath (Item	n 23a) (Type,	Print)	Dr.	VA	Cin	to 2	\cap	Er	str	0	11	\cap
	State		31. Date filed (Mon	th, Day, Year)	111	10.	Registra	ar's Signa	11 1 4 C	11	ווע	VE	oul	43	UI_	Cu	esto	// /	211	201
	stra:				2011	Des	un	, 1	Bar	Red										-1

DHMH 17 Rev 1/2001

11-06875 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Douglass Thompson 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 12, 2011 0719 hrs **Medical Examiner** THOMPSON DOUGLASS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Months Days Hours Director 12/28 1 M 2 F 212-40-0682 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits iny 1 X Yes 2 No BALTIMORE MD permit. Pages i and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ur items 23a nr 28a-f she injury or nither traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ROAD 1032 WITHERSPOON USA 21212 Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 Yes BLACK If Yes, Give Year 1 Yes 2 No specify: Specify: 4 Divorced 3 Widowed 6 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE DENTAL TECHNICIAN Baltimore, MD 21215-0036 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FLOYD THOMPSON, SR LILLIAN WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1013 RADNOR AVE. BAND, MO. 21212
4312 ROBERTIN AVE. BAND, MO. 21206 19a. Informant's Name/Relationship (Type, Print) PIA THOMPSON (DAUGHTER) DOUGLASS THOMPSON, JR (SON) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9/22/2011 BALTIMORE, MD GARRISON FOREST Donation 5 Other Specify: 22. Name and Address of Facility VAUGHN BREENE FUNERING SERVICES 21. Signature of June ral Service Licensee MO 155 4905 YORK ROAD. BATIMORE, MO. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Cardiac Tamponade Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Hemopericardium Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c. Aortic Dissection Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Sa UNPENDED AMENDED s been signed by the attending physician should be detached for use as the burial -Physician/Medi Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy 1 Live birth Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy r this certificate has be al director, page 2 shr performed' death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 V Naturai 1 Yes 2 No Pending after death. Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated

DHMH 17 Rev 1/2001 OCMF 2006

State

Registra

OCME

Assistant Medical Examiner

as seeme

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Donna M. Vincenti, MD 31. Date filed (Month, Day Year)

ORIGINAL

29d. Date signed (Month, Day, Year) 29c. License number

September 13, 2011 O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

			Pie	State of Mar				_	_	lible.	
			for State Registrar	State of Mai		tificate of D		ivieritai riy	Reg. No 20	11 2	9751
		W	Decedent's Name (First, Middle)	e, Last)		inouto or B		2. Date of De	eath		ime of Death
	Physicia Medi		Patricia Y.	Topp		<u> </u>		Septem	by 13 2	Year	235 PM
	Examir	ner	4a. Facility Name (if not institution			4b. City, Town, or	9	1	4c. County	of Death	
3	Funeral		5. Social Security Number	6. Sel 7. Age (1	n yrs. last birthday)	Battynu If Under 1 Year	If Under 24 Hrs.		rth	9. Birthplace (S	tate or Foreign
	Director		215-82-2350	1 🗆 M 2 🗹 F 💆	2 Yrs.	Months Days	Hours Min.	7-6-	1959	Country)	10
<u>d</u>	and show lat	٥	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Loc	ation		,, 0	7.01	10d. Ins	ide City Limits
y. Topp	Maryli 28a-f otifiec	irect	MD		Baltin	nore				1 [Yes 2 No
يُو	Filed within 72 hours after death with the Maryland tall Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	La Avani		10f. Zip Code 216	1/5		10g. Citizen of	What Country?	
ر	eath w	-une	11. Marital Status	12. Was Decedent Eve	r in U.S. 13. W	/as Decedent of His Yes, specify Cubar		pecify Yes or No		e - American Indi	an,
)3 98	after d		1 Never Married 2 Marr		lf 1	Yes, specify Cubar ☐ Yes 2 No		o Rican, etc.)	Blac Specify	ck, White, etc.	1.
Pathlela 215-0036	nours a	Completed by		Year or Dates. nt's Education		ent's Usual Occupa				usiness/Industry	C
61	iin 72 h ie. han "n e Medi	dwo	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4 or 5+)	(Give k	ind of work done di NOT use retired)	uring most of wor	king	1	(1) O	6.00
3 2	led within Hygiene. other tha ent, the A	Be C	17. Father's Name (First, Middle, L	1 Year			40 Mathada Na	or a defined a distant	14ca	19m 4	we
₹ ja	ould be filed with the filed with the marked other matic event, the	10	Claude 7	DPP			Ada Ada	a. Su	, Maiden Surnami	=)	
allimore. Maryland	ਦੂ ਲਾਜ਼		19a. Informant's Name/Relationsh	hip Type, Print)	19b. Mailing	R Street	nd Number or Ru	ral Route Numb	er, City or Town, S	State, Zip Code)	7.
3 2			Lisa Chery C 20a. Method of Disposition	luyner (Sister						<u>200</u> - City or Town, St	
Lewt k	0	N16	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		20b. Place of Dispos cemetery, cremi Lorraine	atony for other place	9-	Date 2/-//	l	more,	
λέγν jaltii	permit. Page Department Important: I any injury o once.		21. Signarire of Fundial Service L			Vacce and Alidres			useral	Service	28
ZZ ■	og a me o		Vaughn (. Melene	5	15/Bal	to. Na	til Pi	1ce 121	729)	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that caused the only one cause on each line.	e death. Do not enter	the mode of dying	ı, such as cardiac	or respiratory a	rrest,	Interv	oximate al Between t and Death
	Ph_sician/ Medical		disease or condition resulting in death)	a. Due to (or a la co	onsequence of):						days
	Examiner	Ļ	Sequentially list conditions,	b Bacter	emia					15	days.
	ed Isit	Examiner	if any, leading to immediate Cause (Disease or injury	Due to (or as a co	onsequence of):						
	e be executed ysician and e burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):				188		
90	te be e nysicia he buri	dical		L d.							
587	ertifica ding ph	/Me	IF FEMALE:	23c. If yes, outcome of	organancy						
XO	eath ce attend	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)	/			te of delivery inth Day	Year
O. B	the d by the tached	hys	9 Unknown	9 Unknown		-					
Division of Vital Records, P.O. Box 6876	requires that the death certificate been signed by the attending phys should be detached for use as the	Completed by Physician/Med	Part II. Other significant condition	ons contributing to death but r	not resulting in the un	derlying cause give	en in Part I.		tobacco use cont		
ords	requir been s	letec	Paris De li					24a. Was		Were autopsy find	
ec.	he law te has age 2	dwo	Assul Col	l disiasi				auto perf	psy ormod?	orior to completic death? 1 Yes 2 N	n of cause of
tal F	ctor, p	Be C	25. Was case referred to medical examiner?			26. Pia	ce of Death (Chec		2 No	TEN Yes 2 12 N	10
Ţ	Physic this ce	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of injury	2 ER/Outpatient		4 ☐ Nursing H		idence 6 Oth		
o uo	nding ath. :: After e fune	icate	1 Natural 5 Pendin 2 Accident Investig	g (Month, Day, Ye	ear) injury	28c. Injury work? M 1 🗆 N	at ∕es 2 □ No	28d. Describe	how injury occurr	ed	
visio	r Atter ter des rector	Certificate:	3 Suicide 6 Could r 4 Homicide determi	not be	At home, farm, stree	et, factory, office		28f. Location (Street and Number	er or Rural Route	Number,
Ö	pital o ours af eral Di filled ir	SalC									
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L Medical E	Physician: To the best of my xaminer: On the basis of exam Nurse Practitioner: To the be	ination and/or investi	gation, in my opinior	 death occurred a 	at the time, date	and place, and du-	e to the cause(s) a	nd manner stated.
	To th withi To th comp		29b. Signature and title of certifier	<u> </u>		29c. License	number			d (Month, Day, Ye	ar)
			Plaxmi H	· Iyer, MD			009		Septemb	w 14 2	011
	121		30. Name and address of person v	vho completed cause of death		tospital	M Ral	timaso			
	Stat		31. Date filed (Month, Day, Year)	32. legistrar's	Signatur	Ne de la constitución de la cons	0,000	V V V V V			
	Registra	ar	SFP 19	2011 Cours	p. 1400	PA					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Uzdilla Physician/ Katherine OBCOAM SEP 2011 Medical County of Death 4c 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Hospital. St. Agnes If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign last birthday) 8. Date of Birth 6. Sex **Funeral** Count Min Days 1 🗆 M 2, 🗆 F 26 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Parkton 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21120 Form Ct. death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 12. 1. Marital Status Black, White, etc. Armed Forces' þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 No WAITE Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) conday (0-12) Home Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 0 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tran Form Ct. 20b. Place of Disposition (Name of cemetery, crematory of other) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Lig CL or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ne disease or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ 10 100 COPD Exacephation disease or condition Medical resulting in death) Due to (or as a consequence of _xaminer Z Exaceabation Sequentially list conditions, Q. Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of) KATH Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 Yes 2 No Day Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed been : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? 2 No certificate 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 2 **N**o 2 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work' 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier PGY2 P25483 09-13-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

3

State Registrar

ORIGINAL

str Agnes Huspital,
32. Registrar's Signature

Box Iti more

9005, Caton Avenue,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Viscoanathan

31. Date filed (Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month 1 Mary L. Williamson 2:200 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Examiner** 4c. County of Death Union Mem. Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, an. 23 217-20-1097 1 🗆 M 2 😾 F 85 Days Country)
MD Hours Director Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? with 1 Funeral USA items 23a 5318 W.North Ave. 21207 Page 1 and 2 should be filed within 72 hours after death viner of Health and Mental Hygiene.

Fant I filem 27 is marked other than "natural", or items urry or other traumatic event, the Medical Examiner mu 11. Marital Status . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: Completed 3 🖵 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry h and Mental Hygiene.
It is marked other than "r traumatic event, the Med (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles McKinney Edna Grant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carolyn Perrin (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Woodlawn Cemetery Sept. 21, 2011 Baltimore, Md. ature of Funeral Serv icens 2Can Vinde Bof Fasteruggs Funeral Home 412 Ε. Preston St. Balto Md. 21213 Part 1. Enter the disease, or complications that caused e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ Severe disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner monas Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury monar attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) signed by the atte I be detached for in the past 12 month Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 P No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending death. 1 🗌 Yes Accident 24 hours after deat Funeral Director: Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death originated at the time, date and place, and one to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial E Univ PKWY Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 3:05 P M Moises Alfonso August Felipe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Kline Hospice House Mt. Airy 5. Social Security Number 8. Date of Birth (Month, Day, Sept 4, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F Hours Cuba Director Yrs 400-66-5069 86 Usual Residence of Deceden 28a-f shov 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director must be notified 1 Yes 2 X No Maryland Frederick Frederick ö 10e. Street and Number 10g. Citizen of What Country? 23a Funeral United States 7005 Hames Court 21703 items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ь þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 1 K Yes 2 □ No Specify: Cuban "natural", Completed 3 Nidowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Mechanical Designer Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked othany injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cipriana Gomez Pedro Alfonso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick, Maryland 21703 Francisco Alfonso / Son 7005 Hames Court 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place) September 4 ☐ Donation 5 ☐ Other (Specify) 2, 2011 Frederick, Maryland Stauffer Crematory ture of innera 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Demenh disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner antinson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 2 🗌 No 1 🗌 Yes Yes 2 N Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) Hospice 1 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No within 24 hours after death

To the Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gentifying Nurse Practioner: To the cest of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a control of my incoming a (Check To the I within 2 To the I 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

4

State

Mamaie

32 Registrar's Signature

Frederica MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hah

31. Date filed (Month, Day,

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me, g920,10/07/2011dhb Certificate of Death State Registrar Reg. NZ Decedent's Name (First, Middle, Last) 2. Date of Death ↑ Month Physician/ 2071 Mei (SOVI Medical Name (if not institution, 4c. County of Death **Examiner** None Birthplace (State or Foreign Country) 8. Date of Birth 12/16/1929 If Under 1 Year If Under 24 Hrs. **Funeral** 1**X** M 2 □ F Hours 81 213-26-6534 Director Yrs. MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 No Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21043 8961 Chapel Avenue United States ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygene. Important: If item 27 is marked other any injury or other trainment. Black, White, etc. 1X Yes 2 No1951-If Yes, Give Year or Dates. 1957 1 Never Married 2 Married Completed by 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BGE Electric Meter Tester 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Katherine Roemer John William Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8961 Chapel Avenue Ellicott City, MD 21043 19a. Informant's Name/Relationship (Type, Print) Dorothy S. Anderson - wife 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 09/10/2011 Ellicott City, MD Good Shepherd Cem. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Hemp Ilhant disease or condition Medical resulting in death) Due to (or as a consequence of Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, If any leading to immedicause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the a P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed? Yes 2 Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate I 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury **FOUND**^{tb}, Day, Year) 28c. Injury at work? 1 ☐ Yes 2**X** No Certificate: 28d. Describe how injury occurred FOUND: 5 Pending daioral 2 Accident Probable fall. Investigation 08/24/2011 11:00 completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8961 Chapel Avenue determined Home Ellicott City,MD Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Harton-Murdi

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29 Day 2011 Physician/ Month 12:45 p^M Margareta Fromiska Hermine Maria Gallowitsch Brown August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Ellicott City Ellicott City Health & Rehabilitation If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F FEB 25, Yea Country) Days ປີ 920 Austria Director 91 213-56-9252 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Ellicott City MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral United States 21043 3000 North Ridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Caucasian permit, Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event the Medical Control of the co 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George's County (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools 12 Cafeteria Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Anna Dub Gallowitsch Hermine Josef 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 Goose Street, Stanley, NY 14561 Christine Parsons / Daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 08/30/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral S Licensee ²². Name and Address of Facility
Thibadeau Mortuary Service, p.a.
7 Park Avenue, Gaithersburg, MD 20877 M00956 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cardioves avar heart disease Immediate Cause (Final [®]hysician Arteriosclerotic 10ars Medical resulting in death) Due to (or as a consequence of): Examiner deme senile E-quentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): executed rate has been signed by the attending physician and page 2 should be detached for use as the burial reas that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed certificate has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 XNo 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. (Month, Day, Year) 1—Natural 5 Pending 1 🗌 Yes 2 🗍 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one) and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 485 marshalee Dr Jorgensen C 31. Date filed (Month, Day State

Registrar

50

9

DO

800°

MARCARETA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	/larylan		epartme <i>Certifica</i> :		lealth and N					
	-		Registrar 1. Decedent's Name (First, Middle, Last)				le oi L	Jean	2. Date of Dea	Reg. N ath	2011	2. Time 7.6att0	
	Physicia Medic	al	Évelina E		OVSKY ———				August		2011 Lear	9:42 A M	
	Examin	er										ery	
	Funeral		5. Social Security Number 6. Sex 7. A	Age (In yrs. la		Months	er 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt	:h y, Year)	9. Birt	hplace (State or Foreign	
	Director		216-25-6158 Usual Residence of Decedent	72	Yrs	5.			June 21	, l	939 K16	V∕Ukraine	
	yland •f shov ed at	ctor	10a. State 10b. County		ty, Town or							10d. Inside City Limits	
	ne Mar or 28a	Dire	Maryland Montgomery 10e. Street and Number	<u> </u>	<u>Gaith</u>	ersbur 1 10f. z	ng Tip Code		_ 	10a. C	Ditizen of What Co	1 ☐ Yes 2 🔀 No	
	s 23a o	Funeral Director	726 Quince Orchard Road #2	201			2	0878		-	ited Sta	•	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 【X Married 3 □ Widowed 4 □ Divorced 12. Was Deceden Armed Forces 1 □ Yes 2 ↓ If Yes, Give Year or Dates.	t Ever in U.S ? No	S. 1			ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: Wh		
15-0	72 hou "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)		(G	ive kind of w	ork done d	ation during most of work	ing	16b.	Kind of Business	ndustry	
212	within giene.		Elementary/Seconday (0-12) College (1-4 o	r 5+)		memake					Own Home		
and	oe filed ental Hy ced oth	To Be	17. Father's Name (First, Middle, Last) Solomon Vollerner					18. Mother's Nam	ne (First, Middle, Sukhonr		n Surname)		
aryl	should the and Me is mark		19a. Informant's Name/Relationship (Type, Print)		19b. M	ailing Addres	ss (Street a	and Number or Run	al Route Numbe	r, City o	or Town, State, Zig	Code)	
ē.	and 2 s Health tem 27		Edward Brailovsky, Son 20a. Method of Disposition	20b E		sposition (Na		Loop Dr. 08/31			Location - City or	20878 Town State	
timor	Page 1 ment of tant: If it jury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te Gar	cometen/ /	rematory or	other place	ance Memo				burg, MD	
Balt	permit Depart Import any inj once,		21. Signature of A Ineral Stanline thereisee	4010	08	Torch	insky arrol	* Hebrew I	Funeral Washi	Hom	ne ton. DC	20012	
	Physician/		23a. Part 1. Emer the disease, or complications that caus shock, or heart failure. List only one cause on each I Immediate Cause (Final	ine.		enter the mo						Approximate Interval Between Onset and Death 2.5 Years	
	Medical Examiner		disease or condition resulting in death) a. Ovarian Carcinona Due to (or as a consequence of):										
		ner	Sequentially list conditions, b.	is à consequ	ueriče ciji								
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events										
0	certificate be executed nding physician and use as the burial transit	edical E	resulting in death) Last Due to (or a	is a consequ	uence or):								
8760	phy the	Medi	IF FEMALE:										
30 III	death ne atte ed for	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcom 1 Live Birtl 4 Pregnan 9 Unknown	h 2 🗀 Feta t at time of c	al death	3 Dectopio		ey			23d. Date of del Month	ivery Day Year	
2000	Attending Physician: The law requires that the sr death. sctor: After this certificate has been signed by the funeral director, page 2 should be detach by the funeral director, page 2 should be detach.	by PI	Part II. Other significant conditions contributing to death	but not res	sulting in th	ne underlying	g cause giv	ven in Part I.				the cause of death?	
rds	law require has been si le 2 should	eted							24a. Was			robably 4 Unknown topsy findings available	
ONSKY EVELINA Division of Vital Records	The law ate has l	Completed							autor perfo	DSV	prior to	completion of cause of	
草西	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?					ace of Death (Chec					
3 ≥ 2	y Physi er this c eral dir	e: To	27. Manner of Death 28a. Date of in	njury	28b. Tim		28c. Injur	4 ∐ Nursing Hey yat	ome 5 Residence		6 Other (Specury occurred	ify)	
江回	eath. or: Afte the fun	Certificate:	1 Natural 5 Pending (Month, £ 2 Accident Investigation 3 Suicide 6 Could not be	Jay, Year)	injui	ry M	work 1 🗆	(? Yes 2 ☐ No					
SNS	after d Direct	Certi	4 D Hamiside determined 28e. Place of I	njury - At ho etc. <i>(Specify</i>	ome, farm, y)	street, facto	ory, office		28f. Location (S City or Tow		and Number or Ru te)	ral Route Number,	
BRAILONSKY, EVELINA Division of Vital Reco	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific Mompleted filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of Certifying Physicians of the basis of Certification Name Physicians of Certification Name Physicians (Certification Name Physicians N	f examination	n and/or in	vestigation, in	n my opinio	on, death occurred a	at the time, date a	and place	ce, and due to the	cause(s) and manner stated.	
20	To the To the To the To the To the	Σ	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	ie best of my	iy kilowledg		9c. License	e number	ce, and due to th	29d. E	Date signed (Month	n, Day, Year)	
			Maler Prymy		00.1.7	Date 2		D23308		A	ugust 31	, 2011	
_			30. Name and address of person wholeompleted cause of Victor Priego, M.D., 6420) Rock	ledge	e Driv	e, Be	ethesda,	MD 208	17			
	Sta Registra		31. Date filed (Month, Day, Year) SEP 02 2011	trar's Signal	ture	wed							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30/4 M just Bnoks uentin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospita 8. Date of Birth (Month, Day, **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace 1 X M 2 - F Days Min Year Country Director Yrs MARYLAND Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No Prince Marslaw ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 10 20782 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?.

1 Yes 2 M No Black, White, etc. by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify. Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Force Maintenance Andrews Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Basks Jr ustus leanura Gray 19a. Informa Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co Shadawn 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22310 Metropolitan 9 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autonsy performed 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 2 🗌 No Investigation 24 hours after death Funeral Director, Suicide Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu and title of certific 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AB1L AH 306 ROAN SUITE NO APOLIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 6 Registrar

11-06632 Rikkia Bracey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Rikkia Bracey	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No. 2011 2976
Physician/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
Medical Examiner	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Fort Washington Hospital 4c. County of Death Prince George's
Farmeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	578 02 5517 1 M 2KF 34 Yrs. Months Days Hours Min. 12/7/1976 Foreign Country)DC
-	Usual Residence of Decedent
Aoy	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Aaryland 28a-f show 1 at ooce. ector	MD Prince George's Temple Hills
the Maryland a or 28a-f sh tified at 0000	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
11215-0036 Id be filed within 72 hours after death with the Maryland Mental Hygiene. narked other thao "natural", or items 23a or 28a-f sho evect, the Medical Examiner must be notified at once. O Be Completed by Funeral Director	5829 Fisher Road #11 20748 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
er death with t , or items 23s r must be not Funeral	1. Martial Status 1. Was becedent Ever in 0.5. 1. Never Married 2 X Married Armed Forces?
fter de	
ours aft.	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
6 n. 72 h ical E	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Property Manager Private
5-0036 ed within 72 hour ed within 72 hour other than "natu other than "natu the Medical Exau Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
215- be filed ntal Hy, rked of	Richard Bracey Helena Walker
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other thao numatic eveot, the Medica To Be Comple	
y, MD 2 and 2 shoul fealth and N tem 27 is n traumatic	David Cater, Jr. / Husband 5829 Fisher Rd. #11 Temple Hills, MD 20748
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other thao "natural", or items 23a or 28a-f she injury or other traumatic eveot, the Medical Examiner must be notified at ooce To Be Completed by Funeral Director	1 X *Burial 2 Cremation 3 Removal from State crematory or other place)
time: Page ument trant:	4 Donation 5 Other Specify: Trinity Mem.Cem. 9/12/2011 Waldorf, MD 21. Synature of Funeral Service Licensee 22. Name and Address of Facility Priscoe-Tonic Funeral Home
Balti permit. Departu Import	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Priscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, MD 20601
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Coronary Artery Dysplasia Death
Examiner	or condition resulting in death) Due to (or as a consequence of):
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ted Insit Examine	cause. Enter Underlying Cause (Uisease or injury that initiated
Exa Exa	events resulting in death) Last Due to (or as a consequence of):
tO, e be executed ysician and burial - transit	x AMENDED 23a,23c,27,per me,g921 11-7-11 sm
60, ate be ohysici ne buri	
Sox 6876(death certificate e attending phys for use as the b	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 X Fetal death 3 VEstopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specific)
h. Box 6876 the death certificate by the attending phy ched for use as the l Physician/M	1 ✓ Yes 2 No 9 Unknown 9 Unknown 9 Unknown
ires that the de signed by the detached for the detached	
Division of Vital Records, P.O. tal or Atteodiog Physiciae: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach sertification: To Be Completed by P	1 Yes 2 No 3 Probably 4 ✓ Unknown
Records, The law requires fitcate has been signage 2 should be Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed?
Recorder the late the page 2	1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysiciao: The l his certificate b director, page	25. Was case referred to medical examiner? Hospital: The second of the
f Vit Physic er this stal dir	The second of th
odiog Pl odiog Pl th. r: After ne funeral	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No
/isic r Atte ter des irecto n by td	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division o spital or Atteodiog nours after death. oeral Director: Aft filled in by the function of the functi	Suicide Could not be determined (Specify) or Town, State)
Division of Vital Records, P.O. Box 6876(To the Hospital or Atteodiog Physiciae: The law requires that the death certificate within 24 hours after death. To the Fuceral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the Howithin 24 F. To the Fuccompletely	one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	O.C.M.E. September 3, 2011
	30. Name and address of person who completed cause of death (Item 23a)
	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State	
Registrar	OLI 2 2011 Lewis 10. April

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ BEALL OSIF 2112 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6215 Bell Station Road Prince George's Glenn Dale Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Maryland Age (In vrs. last birthday, 8. Date of Birth **Funeral** 1 🗆 M 2 🗷 F Months Hours 8/20/1922 **Director** 214-28-2510 89 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Completed by Funeral Director 10c. City, Town or Location 10d. Inside City Limits Prince George's Glenn Dale 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6215 Bell Station Road 20769 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ С. Grover Beall Viola C. Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Abell / Sister 6215 Bell Station Rd Glenn Dale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 9/6/2011 Brentwood, Md Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home laxees 3401 Bladensburg Rd Brentwood, MD 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 191087VP345 DISFACE Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or se a corresquence or): attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attending to be detached for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 🔀 Unknown page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA After this Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident the Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Within 2 10 29b. Signature and title of certific

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3 Day Physician/ CANNETT (605 ELMINI A AUGUS 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENERAL tospita コレンで MONTBOMELL MONTGOMERM Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral Country) Italy 1 □ M 2 🔀 F Days Hours Aug 13, 027-32-2255 1922 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12905 Camellia Drive 20906 **USA** permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. "natural", or items Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Custom Tailors Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Domenica Cucinotta Salvatore Villari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Domenica M. G. Heim/Daughter 12905 Camellia Drive, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Gate of Heaven Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sept. Silver Spring, MD 201121. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ARDLOVACIONA ATHENOSCI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Dus to for as a consequence of if any, leading to mimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and exempleted filled in by the funeral director, page 2 should be detached for use as the burial trains to the funeral director, page 2 should be detached for use as the burial trains to the funeral director, page 2 should be detached for use as the burial trains. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year 4 Pregnant a Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital. Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c License number 30 D007022 MO address of person who completed cause of death (Item 23a) (Type, Print) PHUP PELINCE MD 2532 31. Date filed (Month, Day, Year) State 0 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 W. Month CARROLL GEORGE 22 4:47 P M August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick 5907 Dorsey Dr. Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 1**X**] M 2 □ F Hours JAN. 25, 1943 Maryland 68 Yrs 213-40-4845 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick Frederick 1 Tes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21703 5907 Dorsey Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black

(Give kind of work done during most of working

16b. Kind of Business Industry

18. Mother's Name (First, Middle, Maiden Surname)

Naomi

1227 Palladian Way/ Frederick, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Aluminum company

Carroll

20c. Location - City or Town, State

16a. Decedent's Usual Occupation

life. DO NOT use retired)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Factory employee

Physician/ Medical **Examiner** for State Registrar

10a. State

3 Widowed 4 X Divorced

Elementary/Seconday (0-12)

10

17. Father's Name (First, Middle, Last)

Melvin 19a. Informant's Name/Relationship (Type, Print)

20a. Method of Disposition

15. Decedent's Education

(Specify only highest grade completed)

Kimberly Waddy / daughter

1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State

College (1-4 or 5+)

Carrol1

Director

Funeral

ð

Completed

Be

မ

Physician/

Medical

Examiner

Funeral

Director

28a-f shov at

permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Department of Health and Mental Hyglene in Interpretant: If item 27 is marked other than "natural", or items 23a or 28a-f si Important: If item or other traumatic event, the Medical Examiner must be notified.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the luneral director, page 2 should be detached for use as the burial-transit

Records, P.O. Box 68760

Division of Vital

ant:	4 Donation 5 Other (Specify)		11 Cemetery	08/27/2011 Ho	pe Hill,Ma	ryland
Department Important: I any injury o	21. Signature of Funeral Service Licensee	Peterson		own Pike/Freder		
/sician/	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one complete the complete shock of the complete shock of the condition resulting in death).	tions that caused the death. Do not ause on each line.	enter the mode of dying, such a	is cardiac or respiratory arrest,	li C	Approximate Interval Between Onset and Peath
Medical caminer	. I	Due to (or as a consequence of): Due to (or as a consequence of):				
ysician and ie burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence of):				
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month D	/ ay Year
en signed by	Part II. Other significant conditions contrib	buting to death but not resulting in t	he underlying cause given in Pa		use contribute to the	
page 2 sho	Completed			24a, Was an autopsy performed?	prior to comp death?	y findings available pletion of cause of
ertific ector,	25. Was case referred to medical examiner?	-(4-1-		eath (Check only one)		
his c	1 Li Yes 2 A No	pital: 1		Nursing Home 5 Residence	6 Other (Specify)	
eatn. or: After the funera	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tim inju		28d. Describe how inju	ury occurred	
al Directe		28e. Place of Injury - At home, farm, building, etc. (Specify)	, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural R te)	oute Number,
n z4 nou ne Funer: pleted fill.	(Check 2 Medical Examiner:	n: To the best of my knowledge, de On the basis of examination and/or in ractioner: To the best of my knowled	vestigation, in my opinion, death	occurred at the time, date and place	ce, and due to the caus	e(s) and manner stated.
To the company of the	29b. Signature and title of certifier	Al MD	29c. License number	29d. 0	Pate signed (Month, Da $2/2$)	ay, Year)
W	30. Name and address of person who comp	F11 - 1 1	ve, Freder	ick, MD 2	1702	
State Registra	// III - 4 II / III I	32 Registrar's Signature	parte	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ 56 Day THERESE ANNE COAKLEY 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RAGIONAL SALISBUTY HICOMICO TENINSULA If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8 Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 2 💢 F Months Hours 2-14-1932 NEW YORK 091-30-8807 79 Yrs Director Usual Residence of Decedent show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 X Yes 2 □ No SUSSEX DELAWARE BETHANY BEACH 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 937 LAKE VIEW DRIVE 19930 U.S. items death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 65-69 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify 'natural", Specify: WHITE 3 Divorced Year or Dates. 65-69 Completed Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) the PUBLIC HEALTH NURSING SUPERVISOR HEALTHCARE and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN PATRICK COAKLEY MARY ELIZABETH RILEY t. Page 1 and 2 should b tment of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE A. WHEELER/EXECUTRIX P.O. BOX 1004, BETHANY BEACH, DE. 19930 20a. Method of Disposition
1 ☐ Burial 2 🌣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State P Department of Important: If any injury or MELSON'S CREMATORY 8-31-2011 FRANKFORD, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign mure of Mindral Service Lip insee MELSON ATTENERAL SERVICES, LTD 38040 MUDDY NECK RD, OCÉAN VIEW, 19970 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death ire. List only one cause on each line Immediate Cause (Final Physician/ 1750gt FALLIRE disease or condition resulting in death) CINCHETED LONY Medical Due to (or as a consequence of) Examiner (WEEK REPLACEMENT THE JAYE Sequentially list conditions if any, leading to immediate cause. Liner Underlying Cause (Disease or linjury Due to (or as a consequence of) -transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 1 ☐ Yes ∠ ⊭ 9 ☐ Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy this certificate has death? 1 Yes 2 No Yes 2 N or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Tyes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After Natural (Month, Day, Year) 5 Pending work? 2 \square No Accident
Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one within 7 29b. Signatu/e and title 29c. License number 053551 201 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address SALISBURY MO BA 10+1 James M.0 Toda 100 E. CATTUIL 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State NET D#12perFH, 9/2/2011; EWW, MbCo Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:48 P Physician/ Awdust 30 2011 2011 Alvin DERN Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death County of Death Montgomery Examiner Rockville Maple Ridge Group Home 8. Date of Birth (Month, Day, Year) May 16, 1925 Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours New Jersey 1 💢 M 2 🗆 F Months Director 86 May <u> 143-14-7277</u> Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Rockville 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 Funeral 15908 Maple Ridge Court United States · death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married 1 12 Yes 2 10 No. If Yes, Give W II (Army) Year or Dates. ğ Maryland 21215-0036 within 72 hours after white 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Shoe Store Sales permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Isadore Dern Anna Greenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Silver Wings Lane, Woodstock, NY Cindy Dern, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 09/01/11 Alexandria, VA 4 Donation 5 Other (Specify) Tomonamsky Hebrew Funeral Rome 254 Carroll St., NW, Washington, DC 20012 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician <u>Weeks</u> Failure to Thrive Medical resulting in death) Due to (or as a consequence of) Examiner Months Alzheimer's Disease Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying 24 hours after death.

25 Hours after death.

26 Hours after death.

27 Hours after death.

28 Funeral Director. After this certificate has been signed by the attending physician an integer filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 otin Other (Specify Group HomeHospital: 1 ☐ Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending 1 X Natural Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🕅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the P only one

Registrar

DHMH 17 Rev 7/2009

State

2

0

31. Date filed (Month, Day, Year,

29b. Signature

nd title of certifi

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Suresh K. Gupta, M.D., 9801 Georgia Avenue, Suite 220, Silver Spring, MD

29c. License number

D 32332

29d. Date signed (Month, Day, Year)

September 1, 2011

20902

1. Decedent's Name (First, Middle, Last) Physician/ Cindy Lee Davis Medical 4a. Facility Name (if not institution, give street and number) Examiner Shady Grove Adventist Hospital 5. Social Security Number 6 Sex **Funeral** 856101/26/8 1 □ M 2 🕱 F 51 Director 214-78-8691 Usual Residence of Decedent show 10b. County 10a. State Examiner must be notified at Director or 28a-f Maryland Montgomery 10e. Street and Number or items 23a Funeral 18118 Kitchen House Court 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ื No If Yes, Give 11 Marital Status 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 "natural", 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event; the Medical Lone. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ဂ Richard Murphy 19a. Informant's Name Relationship (Type, Print) Craig David - Spouse 20a. Method of Disposition 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify), re of Jinera Service shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) portic Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician an I that initiated events resulting in death) Last Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a 1 ☐ Yes 243 9 ☐ Unknown Linknown þ Completed phalo Completed filled in by the funeral director, 25. Was case referred to medical Be ဂ 1 Tyes 2 No 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending Investigation 6 Could not be determined Medical 29a. Certifier To the within 2 To the only one) 29b. Signature and title of certifier

Certificate of Death 2. Date of Death 3. Time of Death 1928 M August 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year Days Moth2771959 washington. 10d, Inside City Limits 10c. City, Town or Location 1 Yes 2 No Germantown 10f. Zip Code 10g. Citizen of What Country? 20874 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 ☐ Yes 2 X No Specify: Specify: Caucasian 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Construction Office Manager 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Stubs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18118 Kitchen House Ct., Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State George Washington Cem 09/01/2011 Adelphi, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death spiratory Due to (or as a consequence of): neumou Due to (or as a consequence of). TY cell Non small Due to (or a consequence of): yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Vear Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or inventional in the control of the cause of examiners and on the cause of examination and on the cause of examination and on the cause of examination and on the cause of examination and on the cause of examination and on the cause of examination and on the cause of examination and one cause of examination and Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cotr Dr Rockville MD 9901 20150 Medical ana 0 2 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#19a, per1NF, G919, 9728/2011, WS

State of Maryland / Department of Health and Mental Hygiene

		Ple						ink. Ensure	-		_) .	
		For State		State of M	arylar			of Health and	Mental Hy	_	2011	00	1.0
		Registrar	4 1)			Cei	tificate (of Death		Reg. N	02 U	79	64
Physicia	n/	1. Decedent's Name (First, Middle							2. Date of De Month	eath D	ay Year	3. Time of	
Medic	al	Albert 4a. Facility Name (if not institution		liam	D.	unith	an, Ji		Sept.	4,	2011 Year	11:3	35P''
Examin	er			,	h c	ontor		vn, or Location of Dea	ıtn	4	c. County of Dea Garre		
Funeral	-	Oakland Nurs 5. Social Security Number	6. Sex	7. Ag		last birthday)	If Under 1 `				9. B	irthplace (State o	r Foreign
Director		216-422-6465	1 🔀	M 2 🗆 F		85 ^{Yrs.}	Months D	ays Hours Mir	8/28	719	26 Wes	st Vira	inia
T MO		Usual Residence of Decedent 10a. State 10b. County			140. 00							10d. Inside Cit	
ryland ied a	cto					ty, Town or Lo	cation					1 Ty Yes	*
r 28a notif	Dire	WV G1 10e. Street and Number	ant		В	ayard	10f. Zip Co	ode		10= 0	Citizen of What C		2 🗆 110
vith th	Funeral Director		100	Street				5707			U.S.A.	Journay:	
eath v	-une	11. Marital Status		2. Was Decedent I	Ever in U.	S. 13.	Was Decedent	t of Hispanic Origin? (Specify Yes or No		14. Race - Am	nerican Indian,	
ter de , or it	by	1 🕅 Never Married 2 ☐ Ma	ried	Armed Forces?	No			Cuban, Mexican, Pue	rto Rican, etc.)		Black, Wh		
urs af tural" al Exa	ted	3 Widowed 4 Divorce		If Yes, Give Year or Dates.			ı∟ Yes 2⊈	No Specify:			Specify: Wh	ite	_
72 ho	Completed	15. Decede (Specify only high	nt's Educ est grade	cation completed)		(Give	dent's Usual C kind of work o	lone during most of we	o <i>rkin</i> g	16b.	Kind of Busines	s Industry	
ithin ene. r thar the M	Cou	Elementary/Seconday (0-12)		College (1-4 or	5+)		O NOT use re	missioner	_	ТО	wn of	Bayard	, WV
led w Hygi other ent, i	Be	17. Father's Name (First, Middle,	Last)			Nacc.	2 001111		ame (First, Middle			<u>Dujuzu</u>	
i be fi fental rked tic ev	၀	Albert Wil	llia	m Dur	nith	an S	r.	Emma	Alve	rta	О'Н	aver	
should and Iv is ma		19a. Informant's Name/Relations	hip <i>(Typ</i> e	, Print)		19b. Maili	ng Address (S	treet and Number or F	Rural Route Numb	er, City o	or Town, State, 2	Zip Code)	
nd 2 sealth m 27		Helen Roy/ S	Sist	er		35	Pine S	St., Baya	ard, WV	26	707		
e 1 a t of H if ite or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation	3 🗆 Re	emoval from State		Place of Dispo cemetery, crer	osition (Name of matory or other	r place)	Date	20c.	Location - City of	or Town, State	
t. Pag tmen rtant: njury		4 Donation 5 Other	Specify)				Cemet		9/2011		ayard,		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	icensee	14_1				Address of Facility Ne					
		23a. Part 1. Enter the disease, o	r complic	ations that Zausei	d the deat			Second			and, M	D 21550	
Dhi.i/		shock, or heart failure. List Immediate Cause (Final	only one	cause on each lin	e.			,g,				Interval Bety Onset and I Months	ween
Physician/ Medical		disease or condition resulting in death)	a.	Lung Due to (or as					- 	-		Months	5
Examiner				(1	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying) b.	Due to (or as	a conseq	uence of):							
cuted	хаш	Cause (Disease or linjury that initiated events	С.										
be executed sician and burial-transit	calE	resulting in death) Last	l.	Due to (or as	a conseq	uence of):							
cate be ex physician the burial	edic		d.									<u> </u>	
certific iding ise as	Ž	IF FEMALE: 23b. Was decedent pregnant	23	c. If yes, outcome	of pregna	ancy _					23d. Date of o	delivery	
atter for u	icia	in the past 12 months?		1 Live Birth 4 Pregnant a			Ectopic pred Other (speci				Month		/ear
the d	Physician/Medi	9 Unknown		g 🗌 Unknown									
s that gned I	by	Part II. Other significant conditi	ons conti	ributing to death b	out not res	sulting in the u	underlying cau	se given in Part I.				to the cause of d	
quire:	ted	Dementia							. 1	Yes :	2 □ No 3 □	Probably 4 🔀	Unknown
law re las be	Completed	COPD								opsy	prior to	autopsy findings a o completion of c	available ause of
The cate h	ပ်								1 🗆 Yes	formed?		/ /es 2□No	
ician: sertifii ector,	Be	25. Was case referred to medical examiner?		spital:				26. Place of Death (Ch					
Phys this ral dir	2	1 ☐ Yes 2 🔀 No 27. Manner of Death		1 Inpati		ER/Outpaties 28b. Time of		Injury at	Home 5 Res			ecify)	
nding tth. : After e fune	cate	1 X Natural 5 ☐ Pendi 2 ☐ Accident Invest	ng igation	(Month, Da		injury	M 200.	work? 1 Yes 2 No	20d. Describe	now inju	ary occurred		
Atter	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be	28e. Place of Inj			eet, factory, of	ffice				Rural Route Numb	er,
talor rs afte al Dir				building, et	c. (Specin	у)			City or To	wn, Stat	re)		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical							time, date and place, opinion, death occurre					nner stated
the H	Me	only one) 3 🗌 Certifyin	g Nurse F				death occurred	at the time, date and		he cause	e(s) and manner a	as stated.	
6 ≥ 6 ⊗		29b. Signature and title of certified		emi	00-			cense number			ate signed (Mor		
•		30. Name and address of person						26154	_	9	/7/201	1	
	4	Paul Danie						es Dr., (akland	_ M	D 2155	0	
State	e	31. Date filed (Month, Day, Year)		2. Registr			- 1101 C	DI DI O	Jakrana	, 11	<u>, , , , , , , , , , , , , , , , , , , </u>		
Registra	r	SEP - 8 2	UII	A sheet	. A.	A AV							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 04 Day Physician/ 09 Month 201 Tear 9:25 a Annabel1 DeWitt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Garrett 103 S 5th St 0akland Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) 930 1 M 2 KF Days Hours Min. 05 04, Director MD 217-28-7713 21 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Garrett 0akland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21550 103 S 5th St Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? s filed within 72 hours after de ital Hygiene. ed other than "natural", or it Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) commercial cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H is marked of Steward S. Savage Minnie DeWitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Box 63 Gormania, WV 26720 Tammy Wilson-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Cemetery 9/6/2011 Oakland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home PA 21 N 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ liver metartase Pancroatic Muss disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner months Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): death certificate be executed Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 Yes 2 No Month Dav Year 9 Unknown signed by the P.O. Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director; Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2. No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

po Box

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E

glan Clinic

32. Registrar's Signature

Fay Mo

WV 21249

2011

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

			ease Type or Pr			delible Ink		-		_	ble.		
	-	1 - For State Registrar				tificate of D			Reg. N	20		297	171
Discontinuity	. ,	1. Decedent's Name (First, Mic	ddle, Last)				-	2. Date of De	eath		Vanu	3. Time of	Death
Physician Medica		Madeline	Jane	Fri	end			sept.	3,	201	1	3:28	АМ
Examine		4a. Facility Name (if not institute Garrett Co.	,		al	4b. City, Town, or Oakla	nd		4	c. County o	ret	t	
Funeral Director		5. Social Security Number 283 – 24 – 1146	6. Sex 1 \(\text{M} \) 1 2 \(\text{M} \) F	ge (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		8. Date of Birth (Month, Day Year) 3/18/1927			9. Birthplace (State or Foreig	
at	5	Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, T	own or Loc	ation		_			1	0d. Inside City	y Limits
8a-f s	Director	MD Ga	rrett	Mc	Henr	У						1 🗆 Yes	2 🌠 No
a or 2		10e. Street and Number				10f. Zip Code		10g. Citizen of What C					
ms 23 must	Funeral	1754 Deep		E	140.11	21541	. 0 : : : 0 : 6						
or itel	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ N	12. Was Decedent Armed Forces Varried 1 Yes 2	?	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	to Rican, etc.)	lican, etc.) 14. Race - A			merican Indian, /hite, etc.	
ral",		3 🏿 Widowed 4 □ Divore	If Von Civo	2 110	1	☐ Yes 2 🔀 No	Specify:		Specify:			ite	
"natu	plet		edent's Education ighest grade completed)			ent's Usual Occupa		rking	ina 16b. Kind of Bus			dustry	
ygiene. her than rt, the Mo	e Completed	Elementary/Seconday (0-1	2) College (1-4 or 5 +	5+)	life. DC	on NOT use retired)			Pι	ıblic	c/Co	llege	
portion is used if the standard period within 12 hours are used in the manyland limportant; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle Howard	R. Sten	ger			18. Mother's Na Marga	me (First, Middle ret		n Su <i>rnam</i> e) ane	J	ones	
raums		19a. Informant's Name/Relation			19b. Mailing	g Address (Street a	nd Number or R	ural Route Numb	er, City o	or Town, St	ate, Zip (Code)	2152
em 2		Kristen En 20a. Method of Disposition	llow/ Daught			Friend	sville	RD.,		Location - (
nent of ant: If it ury or o			ion 3 Removal from Stater (Specify)	e HOT	ese M	ethodi#s	t 9/	10/201				.lle,	MD
Depart Import any inji		21. Signature of Funeral Service	Certicens de Mattere d		22.	Name and Addres 79 Mill	s of Facility N er St.	ewman i	Fune	eral ille	Hom , ME	nes P. 2153	A. 6
nysician/ Medical		23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	ist only one cause on each li	SPPF	ice	mia		c or respiratory a	ırrest,			Approximate Interval Betwood	
xaminer		resulting in death)	Due to (or as	s a consequen	ice of):	ionia	j					Nau	-
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	s a consequen									
an and ial-transit	Examin	Cause (Disease or iinjury that initiated events	C								_		
sician a burial-	— I												
s the	ledic		d										
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Fetal d at time of dea	eath 3	Ectopic pregnancy Other (specify)	у			23d. Date Mon		•	'ear
ed by detac	by Ph	Part II. Other significant cond	ditions contributing to death	but not resulti	ing in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco	use contri	bute to th	ne cause of de	eath?
en sigr uld be						•		1 🗆	Yes 2	2 🗆 No	3 🗆 Pro	bably 4	loknown
as be	Completed							24a. Was	s an opsy			psy findings a	
cate h	5							per 1 🗆 Yes	ormed?		eath?	2 🗆 No	
certific ector,	Be	25. Was case referred to medic examiner?	Line-iteli			1	ace of Death (Che	eck only one)		· · ·			
r this	유	1 Yes 2 No 27. Manner of Death	14 Impa 28a. Date of in	atient 2 ER	Outpatient Bb. Time of	28c. Injury	4 U Nursing	Home 5 Res				/)	
ath. r: Afte e fune	icat	1 → Natural 5 ☐ Per 2 ☐ Accident Inve	nding (Month, D	ay, Year)	injury	work'	? Yes 2 🗌 No			.,			
after de Director	Certificate:			njury - At home etc. (Specify)	e, farm, stre	et, factory, office		28f, Location City or To			r or Rurai	l Route Numbe	e <i>r</i> ,
24 hours Funeral leted filler	Medical	(Check 2 L Medic	ring Physician: To the best of all Examiner: On the basis of	examination ar	nd/or investi	gation, in my opinio	n, death occurred	l at the time, date	and place	ce, and due	to the ca	use(s) and mar	ner stated
within To the	Σ	only one) 3 L Certify 29b. Signature and title of cert	ving Nurse Practioner: To th	e best of my kr	nowleage, a	29c. License		lace, and due to t		ate signed		-	
		> / X	1			D239	79		-	9,11			
	1	30. Name and address of pers	on who completed cause of	death (Item 23	3a) (Type, Pr								
	0		A. Gorals			Fourth	st.,	Oakland	d, M	ID 21	550		
State	_	31. Date filed (Month, Day, Yea		trar's Signature	La	del							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kathryn McKee Giebel 26^{ay} 2011 11 Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1608 Rock Creek Dr. Apt. Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days Hours 579-18-8221 87271921 90 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a.4 ما 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 QYes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1608 Rock Creek Dr. Apt. 5 21702 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) federal Elementary/Seconday (0-12) College (1-4 or 5+) security government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arnold B. McKee Georgeanna Griswold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21702 1608 Rock Creek Dr. Apt. 5, Frederick, MD 19a. Informant's Name/Relationship (Type, Print) James Giebel (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place

Gate of heaven 1 X Burial 2 Cremation 3 Removal from State heaven Cemetery9/1/1|Silver Spring, MD 4 Donation 5 Other (Specify) nature of Aunera ²DomanddreB: Farihompson Funeral Home Middletown. MD 21769 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one au e on each line. Approximate erval Between Immediate Cause (Final Onset and Death Enysician/ disease or condition Themy Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying
Cause (Disease or iinjury
that initiated events
resulting in death) Last sequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 L Fetal Gea Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 1 Tyes should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \nearrow Residence 6 \square Other (Specify) 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 24 hours after deal Funeral Director: Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Scrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29c. License number

Registrar

0

State

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

01

MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Daisy May Graham 09 2011 3:25 а Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Oakland Nursing & Rehab Center Garrett 0akland If Under 1 Year If Under 24 Hrs. 01^{(Month} Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 M 2 X F Months Days Hours Min. 01 Year 1910 **Director** Yrs 219-44-0840 101 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD 0akland Garrett 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 462 Graham Road 21550 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Midowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home it. Page 1 and 2 should be filed will rtment of Health and Mental Hygiei rtant: If item 27 is marked other I njury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Wilbert Sliger Mary Ellen Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford Graham-son 462 Graham Road, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If i any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State /14/2011 4 ☐ Donation 5 ☐ Other (Specify) Co. Garr. Gardens Memorial Oakland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home PA 2nd St, Oakland, MD 21550 Ν. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UCEN disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2000001 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director, After this certificate has performe 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Tyes 2 No Accident Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01 D15333

Registrar
DHMH 17 Rev 7/2009

Thomas G. Johnson, M.D., 311 North Fourth St, Suite II, Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signa

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jesse. 0010 Medical 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death **Examiner** County of Death Regional Medical Contor Western MD Allegany Cumberland 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours **Director** 218-44-4815 65 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director WV Preston Aurora 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 124 Darlene Drive 26705 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) al Hygiene. Jother than "natural", or iten vent, the Medical Examiner I 11. Marital Status 14. Race - American Indian, Was Deceden Ever Armed Forces? 1 ☐ Yes 2 🙀 No Black, White, etc. þ 1 Never Married 2X Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Repairman Automobile Ith and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dortha A.Dixon Beall George S. Goudy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other tratonce. Barbara A. Goudy/Spouse 124 Darlene Drive, Aurora, WV 26705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 9/3/2011 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery Aurora, W 21. Sigr of Funeral Service Lice see 22. Name and Address of Facility Arthur H. Wright Funeral Home 105 Highland Ave., Terra Alta 26764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ LUNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CORONARY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury OBSTRUCTIVE PULMONARY DIS Exami that initiated events resulting in death) Last Medical IF FFMALE Physician/ 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMBOLUS 1 Fes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 2 🗌 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

physician and the burial-transit requires that the death certificate be executed Box 68760 the attending phoched for use as the P.O. I signed by the Division of Vital Records, certificate has Physician: this After or Attending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu the Hospital

show

28a-f

ò

items 2 death

within 72 hours after

Maryland 21215-0036

altimore,

29a. Certifier only one

Medical

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of detifier

CARDIOTHORACIC D0066694

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12502 WILLOWBROOK RD. CUMBERLAND, MD 21502 SUBRATO MID

31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 201 18:23P ^M <u> Alex Gunter</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 09-12-1**X X**M 2 □ F Months Hours Days So.Carolina **Director** 69 Yrs 578-54-381 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD PG ty Yes 2 No Brandywine 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Funeral Page 1 and 2 should be filed within 72 hours after death with 15608 Gillmore Greens Court 20613 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1961
If Yes, Give
Year or Dates. 1981 Black, White, etc. δ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Specify. Black marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lorton Cor. Fac. Correctional Officer Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ 27 is marker er traumatic e Lattimore Gunter Carrie Ready 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greens Court Beatrice L. Gunter (Wife) item 2 Brandywine, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Zion Hill Bapt Ch 09-10-201 Salley, Caroí 22. Name and Address of Facility
Ralph Williams, II Funeral Service P.A.
5202 PrincetonsDelightDr., Bowie MD 20720 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r. spir flory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine nding physician and use as the burial-transit Due to (or as a cop nce of Physician/Medical death certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for signed by the a Id be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 2 🗂 No 1 Yes 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e Hospital or Attending Physician: The law 124 hours after death.
e Funeral Director: After this certificate has k page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🛂 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Man r of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 V Natural 5 \square Pending Accident 1 Yes 2 🗌 No Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier прleted (Check To the within 2 To the F only one 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17/W. C

State

Registrar

Date filed (Month, Day, Year)

SEP 0 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2\o^1 4:30 AM Elizabeth Hamburg Marian Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Homewood at Crumland Farms Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours June 4, 1931 Pennsylvania Director 80 193-24-1263 Usual Residence of Decedent 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director or 28a-f sh notified 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 5 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Inportant: If them 27 is marked other than "natural", or items 23a or improprient if them 27 is marked other than "natural", or items 23a or improprient proprient in most be. any injury or other traumatic event, the Medical Examiner must be. Funeral 5803 Meadow Drive 21702 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black. White, etc. 1 Never Married 2 X Married Completed by White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Homer Miller Elizabeth Smaling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Hamburg / Husband 5803 Meadow Drive Frederick, Maryland 21702 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Fairview Township, 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) September 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania Olivet Cemetery 3, 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the the base, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cardiomyora disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Myeloma of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has death? within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 1 16 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Curtifying Nurse Practices: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year. MT D60417 8-29-2011

Registrar
DHMH 17 Rev 7/2009

State

17/60

0

ò

Ó

Mysician as.

Uhnson

lhomas

Dr. Frederica MD 21707

Name and address of person who completed cause of death (Item 23a) (Type, Print)

65

-C

Registrar's Signature

Shah

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Month Physician/ 9:36PM M August Darrell Hazard Medical 4c. County of Death
Prince George's 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Accokeek 15818 Livingston Rd. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 10/17/1967 1 **X** M 2 □ F Rhode Island 43 Director 037-52-7893 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a State 10c City Town or Location Director 1XX Yes 2 ☐ No PGAccokeek MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20607 15818 Livingston Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married **Black** 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Church Reverend 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Diana Barnes Rev. Wallace Hazard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Rodman St. Wakefield RI 02879 Rev. Wallace Hazard/Father 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/7/2011 Kingston RI 4 ☐ Donation 5 ☐ Other (Specify) Fernwood Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home quest 3035 Old Washington Rd. Waldorf, MD 20601 mo1164 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final MYO CARD IAL INFARCTIC Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Vear Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has performed?

Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) eral Director: After the filled in by the funeral 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: ☐ Natural ☐ Accident 5 Pending 1 Yes 2 No Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Destriying invalidation in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practicos is the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practicos is the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Nurse Practioner To the best of my Japaniedge, deeth 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P^{M} 2:30 2011 Medical <u>September</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 402 Suffolk Capitol Heights Ave Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day,) 1 🗆 M 2 🕱 F Hours Director 242-16-4947 87 1923 North Carolina Nov. Usual Residence of Decedent rms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Prince George's Md Capitol Heights 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 402 Suffolk Ave 20743 USA items ? and 2 should be filed within 72 hours after death we Health and Mental Hygiene.
tem 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. the Medical Examiner Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Private traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မှ James Spruil1 Carrie Darden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lois Fitzgerald / Daughter 402 Suffolk Ave Capitol Heights, Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 9/7/2011 Brentwood, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home nances 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or cause (Final) 3401 Bladensburg Rd Brentwood, Md 20722 Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Uterine Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury) Examine Due to (or as a consequence of): transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Live Betal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 K No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 Yes 2 X No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? Atherosclerotic Cardiovascular Disease 24a. Was an To the Hospital or Attending Physician: The law within 24 burus after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. autopsy performe 1 Yes 2 No Yes 2 K N 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 🗆 Other (Specify) 1 Yes 2 X No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident work? 1 🔲 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 000 9/2/2011 D050545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Godswill O. Okoji

7517 New Hampshire Ave

20912

Takoma Park, Md

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

				_								II Copie Iental Hy			ble.		
	•	For State Registrar	•	Otato o		arra /			te of C				Reg. N	201	1	297	79
Physicia	n/	1. Decedent's Name (First, Middle		0		77	1					2. Date of Do	D	^a y 20	Year 011	3. Time of	
Medic Examin		4a. Facility Name (if not institution			arola	Ken	nedy	4b. City	, Town, or	Location	of Death	Septem		c. County o		0826	AM
LXdiiiii	Ç.	1480 Glebe Roa	.d					,		ille				Cec			
Funeral Director		5. Social Security Number 218-38-4951	6. Sex 1 🗆	м 2 🗓 F	7. Age (In y	rs. l a st t	birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth ay, Year , I	921		place (State or try)land	Foreign
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Location Earleville											10d. Inside Cit	,	
the Ma or 28		Maryland Ce 10e. Street and Number	<u>cil</u>	_		La	rievi		ip Code				10g. C	itizen of W	nat Cou	ntry?	
h with	nera	5 Old Farm Roa	ıd	21919						United				States			
r deat or iten niner r	y Fu	11. Marital Status1 ☐ Never Married 2 ☐ Mar		Armed Fo	Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No							-	14. Race - American Indian, Black, White, etc.				
rs afte Iral", c Exam		3 X Widowed 4 □ Divorced	If Yes, Giv	If Yes, Give 1 ☐ Yes 2 🗓 No Specification of the Year or Dates.					Specify	:			Specify: White				
72 hou n "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired)					ng	16b.	Kind of Bus	iness In	dustry	
within giene.	Con	Elementary/Seconday (0-12)		College (1	-4 or 5+)	4 or 5+) life. DO NOT use retired) Butcher's Assistant						Grocer			ery		
e filed ttal Hyg ed oth event,	To Be	17. Father's Name (First, Middle, Last)										ame (First, Middle, Maiden Surname)					
ould b nd Mer mark	_	Benjamin T. Cr								Dorothy E. Price Number or Rural Route Number, City or Town, State, Zip Co					Code)		
id 2 sh salth ar n 27 is er trau		Joseph A. Kenr		/Son 14				Glebe Road, Earl						219			
ge 1 an t of He If iten or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □ R€	moval from	State	ceme	e of Dispos etery, crem	atory or	other plac			ember		Location - (
nit. Paç artmer ortant injury		4 Donation 5 Other (S	-			Zior	n Ceme				14, 2			Cecil		ıls, P.	Α.
permit Depar Impor any in		Fruit I	(2)	Cris	ma 1							Street				-	
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complic only one	ations that o	caused the dach line.	death. D	o not ente	0	٨	•			arrest,			Approximate Interval Bety Onset and D	veen
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a.	Due to	for as a con-	segueno	ce off:	Co	lon	Car	nce	V	<u> </u>		-	Oriset and L	Jean
Examiner	L	Due to (or as a consequence or).															
ped sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	2	Due to	(or as a cons	sequend	ce of):										
executed an and ial-transit		that initiated events resulting in death) Last	t initiated events C.														
ate be ohysicia the bur	dica	d										\perp					
certifica nding partitions is as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23	c. If yes, out	tcome of pre	egnancy	,							23d. Date	of deliv	/ery	
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burian to the funeral director, page 2 should be detached for use as the burian to the funeral director.	by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 🕱 No 9 ☐ Unknown			Birth 2 gnant at time nown			Other (pregnancespecify)	У				Mon	th	Day Y	/ear
ires that t signed b d be deta	d by P	Part II. Other significant condition	ons cont	ributing to a	death but not	t resultir	ng in the ur	nderlying	cause giv	en in Part	l.					the cause of do	
w requisible been 2 shoul	Completed											24a, Wa	s an			opsy findings a	
The la cate ha page 3	Com												formed?	d	eath?	2 🗆 No	
sician: certific irector,	Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Но	spital:					Oth	er.		k only one)		- TI OU		Son's	
ding Phy h. After this funeral di	ate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendii		28a. Date	of injury oth, Day, Yea	28	b. Time of injury	M M	28c. Injury work	y at		ome 5 Res 28d. Describe				^y Resid	ence
or Atten	Medical Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be		e of Injury - A		, farm, stre			103 2 2	I NO	28f. Location City or To			or Rura	al Route Numb	oer,
ospital hours a uneral L	lical (29a. Certifier 1 Certifying															nnor stato
the Hithin 24 the Fu	Med	//	Nurse	ractioner:	To the best of	of my kn	nowledge, d	eath occ	urred at th	e time, dat	e and plac	ce, and due to	the cause	e(s) and mar	nner as s	tated.	illei statet
\ 5.≥ 6 8		29b. Signature and title of legifie	1			и	D				191)		ate signed			
Par		30. Name and address of person	who con	pleted caus	se of death ((Item 23	Ba) (Type, P	rint)	<u> </u>	14	116	-EA C	HIC	APEN	IFA	2011 174, M	D
St.		KHAN, SHA-HNAU 31. Date filed (Month, Day, Year)	1A2	25.	33 /\ C	060)	STINE	HE	KMH	VITW	y,50	14/7	TIE >	TIEA		1/21	415.
Stat Registra		SEP 1 9 2011	Der	ma)	Registrar's Si	par	Kasa										

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Avianna Alexis Lopez-Hernandez Day 2011 Year Month Physician/ 26. 0521 August Azianna Alexis Lopez-Hernandez Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) (Month, Day, **Funeral** Maryland Days 1 🗆 M 2 🖪 F Months Director N/AAug. Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hant: If item 27 is marked other than "natural", or items 23a or 28a-f sho usuy or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 1 🗌 Yes 2 🛢 No Gaithersburg Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20879 19506 Taverney Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Guatemalan 14. Race - American Indian. Was Decedent Ever in U.S. 11 Marital Status Black White, etc. Armed Forces 1 Mever Married 2 Married 1 ☐ Yes If Yes, Give 2 No Completed by Baltimore, Maryland 21215-0036 Yes 2 No Specify: Specify: Hispanic 3 Widowed 4 Divorced Peurto Rican Year or Dates 16b. Kind of Business Industry 16a Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Infant 0 Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mirla Hernandez Lusvin Jose Lopez Rivera 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19506 Taverney Drive, Gaithersburg, MD 20879 Mirla Hernandez/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 Burial 2 Cremation 3 Removal from State Sept.2,2011 Silver Spring, Maryland Gate of Heaven Cem. 4 Donation 5 DOther (Specify) 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 20872 21. Signature of Fun Service Ligens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Eh sician/ Extreme Prematurity disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Chorioamnionitis Sequentially list conditions, Examiner Due to for as a conse tuence of cause. Enter Underlying the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ■ No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 🖪 No ■ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 Ves 2 No Investigation Accident within 24 hours after deat

To the Funeral Director:
completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

1. 1. 1. A. A. A.

Diane Laurin, MD

D57376

9850 Key West Ave., #320, Rockville, Maryland 20850

August 26, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ lene 2C)), Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, **Examiner** St. Mary's Leonardtown St. Mary's Nursing Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Minn Days Hours Min. (Month, Day, Year 1 □ M 2 😾 F 468 32 9995 Yrs Director 1933 March 13 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No Leonardtown Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number 23a Funeral 20744 United States 21580 Peabody Street or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1. Marital Status þ 1 Never Married 2 Married 1 ¥ Yes 2 □ No If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify. "natural", White 3 X Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ella E. Fregin George H. Swanson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 104 Oueen Mary Court, Kill Devil Hill, NC 27948 Carol Rauen (Daughter) 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington, Virginia Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, INc 6633 Old Alexandria 21. Signature of Funeral Service Licensee MO1555 Ferry Road, Clinton, MD 20735 Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on particles. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ 115 disease or condition resulting in death) Medical ∉xaminer Sequentially list conditions, Due to (or as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lifled in by the funeral director, page 2 should be detached for use as the bunal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 🔀 25. Was case referred to medica 26. Place of Death (Check only one) Be Other 2 📈 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 2 🗌 No 1 Yes Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 2gb. Signature an title of certifier

Registrar

Kirandeep Kaur, MD 21580 Peabody Street, Leonardtown, MD 20650

Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Physician/ :45 p orothu Meminger Medical 4a. Pacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Privce 8304 NUTTI Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year, Country) 1 M 2 N F 226-80-Director 9tamuton Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State injury or other traumatic event, the Medical Examiner must be notified at Director inton 1 Yes 2 No Maryhal Prince 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5 Funeral items 23a 8804 USA 20735 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Force Black, White, etc ò 1 Never Married 2 Married δ 2 X No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be permit. Page 1 and 2 should be flec
Department of Heatth and Mental Hy
Important: If item 27 is marked oth
any injury or other transcriptions. 17. Father's Name (First, Middle, Last) 's Name (First, Middle, Maiden Surname) မ S EVANS Balcenbyr Samue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meminger 20735 berume 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Waldurf P.M 21. Signature of uneral Service Licenses Vame and Address of Facility 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ zome disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. der Underhäng Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed -tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death the Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 □ Probably 4 □ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1
Yes 2 No 24a. Was an autopsy performed has page 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 🗌 Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Signature and title of certific 29c. License number 29d. Date signed (Month. Day.

State Registrar 30. Name and add

Year)

SEP 06

9200 B

20774

son who completed cause of death (Item 23a) (Type, Print)

32. Re

DO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day McComb Month Marie 7:15:A Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico Ouantico 6442 Quantico Road 8. Date of Birth Birthplace (State or Foreign Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Country Missouri 1 □ M 2 🛛 F Days Months 10-12-1918 Director 496 10 8456 92 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Directo 1 Yes 2 No Wicomico Quantico MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21856 6442 Quantico Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Eastern Stainless Stee should be filed with h and Mental Hygien is marked other th 12 Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Sarah Ethel Ruggles Roy L. Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) and 2 si Health a 8354 Sunset Drive Ellicott City, MD 21043 permit, Page 1 and 2 Department of Health Important: If item 2; any injury or other th Barbara K. King/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Mem. Gard. 9-10-2011 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final .Ph, sician/ disease or condition Medical resulting in death) **Examiner** Eequantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a requires that the death certificate be executed burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 use as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month for Day Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 sl Hospital or Attending Physician: The law autopsy performed2 ☐ Yes 2 No. 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 2 Accident
3 Suicide
4 Homicide filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Medical Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 1457291 hy sician address of person who completed cause of death (Item 23a) (Type, Print) 10 Swite 101, Salisbu State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 6:15 OM Catherine T. Murray 2011 Medical 4a. Facility Name (if not institution, give street and number)
St. Alues tlosith 4b. City, Town, or Location of Death 4c. County of Death Examiner BAltimore tho sizi tal None If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 10/21/1925 1 🗆 M 2 🔀 F 85 PA Director 192-16-7086 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 XNo Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number United States Funeral 21043 4633 Dower Court Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 14. Bace - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna DeNucci Anthony Tuccio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4633 Dower Court Ellicott City, MD Charlene Furletti - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD 109/08/2011 Garrison Forest Vet. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumoniA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner OPD Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ears for use as the burial-transit signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the buse of the b Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No 1 Live Birth
4 Pregnant a
9 Unknown Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ray autopsy performed 2 No 2 No 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 E Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tit

State Registrar Υ

30. Name and address of person who completed

2011

31. Date filed (Month, Day, Year) SEP 0 6

2

MUR

sark

S. CATON AVE

2011

M.D

cause of death (Item 23a) (Type, Print)

mint

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Leo McGowan September 2017 2:19 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 309 Ross Westernport St. Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 5. Social Security Number 214-36-6465 OCT. 2 Year) 937 1 X M 2 D F Months Maryland 73 Director 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland Director MD Allegany Westernport 1 X Yes 2 ☐ No 10f. Zip Code 21562 10g. Citizen of What Country? 10e. Street and Number 309 Ross St. Funeral United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. white 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 tal Hygiene. Elementary/Seconday (0-12) Paper Manufacturer Coater Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file
Department of Health and Mental H
Important: If item 27 is marked ott
any injury or other from Samuel 2 McGowan Ann Farrell Mary 19a. Informant's Name/Relationship (Type, Print) Judith McGowan/ wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Ross St, Westernport, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Peters Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 09/13/2011 Westernport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licenses - Tu 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early line. val Betwee Immediate Cause (Final Ph_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause Disease of linjury use as the burial-transi that initiated events resulting in death) Last attending physician Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown ate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law in thin 24 hours after death.

the Funeral Director: After this certificate has be autops 1 Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only 2 🕽 4 Nursing Home မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accider injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: July best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu

State Registrar 31. Date filed (Month, Day, Year) SEP 13 2011

Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Robert Bess, 122 Ashfield St, Piedmont, W 26750

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year MORTON FREID A MAE 2:30 09 011 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death SWANTON 322 South stde cane GOTARE II . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🏝 F 78 Days Months Hours Min. March 26 1933 Maryland 218-30-0724 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Garrett Swanton 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō . Page 1 and 2 should be filed within 72 hours after death with the trnent of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or jury or other traumatic event, the Medical Examiner must be 1 21561 Funeral 322 South Side Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Security Service Elementary/Seconday (0-12) College (1-4 or 5+) Security Guard Be 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Ellen Shriver 17. Father's Name (First, Middle, Last) ည Walter Lee Smith 19a. Informant's Name/Relationship (*Type, Print*) John Morton JR/ son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 322 South Side Lane, Swanton, Maryland 21561 Important: If item 2 any injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State Bloomington Cemetery 09/14/2011 Bloomington Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Servic Acenses Boal Funeral Home 22. Name and Address of Facility 21562 111 Church St, Westernport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant Month 5 Other (specify) Pregnant at time of death 9 Unknown been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? this certificate 1 Yes 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t 1 Natural work?
1 Yes 2 No injury 5 Pending death. 2 Accident
3 Suicide Investigation after death 6 \square Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,

Registrar

State

30. Name and address of person who completed cause of

SEP 13 2011

31. Date filed (Month, Day, Year)

Wolf Acres Dr Oakla

State of Maryland / Department of Health and Mental Hygiene

0011 207									
2011 297	ľ	2	0 9		2	9	7	8	

		1- For State Registrar		Certi	ficate of	Death			Re	g. No.		
Physicia Medical Examir	ın/	7 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year										
wedicai Examii		Arlen W. Man 4a. Facility Name (if not institution		umber)	41	o. City, Town, or	Location of		August 30,	4c. County o	f Death	0817 hrs
	E	Meritus Medical Cente		,		Hagerstown				Washing	ton	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days		24Hrs. Min.		h(MM/DD/YYYY	9. 8irth Foreign	Lorain, OH
Director		300-64-2210	1X M 2 F	52	Yrs.	I VIOITIII Days	Tiodis	IVIII I.	09/19/	1958	Cour	itry)
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Locatio	n					1	0d. Inside City Limits
*	ا	MD Washi	ngton	Нас	erstown							1 X Yes 2 No
laryland 18a-f show at once.	Director	10e. Street and Number	ingcon	liag.	erscowi	10f. Zip Code		_	10	g. Citizen of Wh	at Countr	y?
with the Maryland ns 23a or 28a-f sho be notified at once		91 Manor Driv	e Apt A4		:	21740				United	1 Sta	ates
th with	Funeral	11. Marital Status 1 Never Married 2 M		cedent Ever in U.S. orces?		Decedent of His s, specify Cuban				14. Race White		an Indian, 8lack,
ter dea			1 Yes	orces? 2 No ar	1 ,	Yes 2X No	specify:			Specify:]	Blacl	ζ
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Exminer	d b	15. Decedent's Education (Spe	or Dates:		6a, Decedent	s Usual Occupati	on (Give ki			16b. Kind of 8u		
6 n 72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	_			ise remed	٦)	Priv	a t a	
15-003(filed within Hygiene. d other tha	E	17. Father's Name (First, Middle,	Last)		rroje	ct Manag		Name (F	irst Middle M	I I I I V		
21215-0036 and be filed within 7 Mental Hygiene. marked other than	Bec	William Mance					Burr		Brown			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "matural", or items 23a or 28a-fab. natic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relations			-	Address (Street						
MD and 2 sho tealth and tem 27 is traumati	-	Veronica Mance	/ Sister			illard A			19 Chev	y Chase		
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and Important: If tiem 27 is rightry or other fraumatic		1 X Burial 2 Cremation	n 3 Removal f	rom State cre	matory or other	er place)	·]				•	
Itim it. Pa	1	4 Donation 5 Other State 21. Signature of Funeral Service		Fort	Linco.	In Cemet				Brentwo		
Depa Depa		Auch /1	Jash	ests		l Bladen						
Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the death. D								Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary	Thromboembo	olism							Death
			Due to (or as	a consequence of):								
	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequence of):								
	Examiner	(Disease or injury that initiated events resulting in death) Last	С.	a consequence of):								
760, icate be executed physician and the burial - transit	교 교		d									
O, the existian	흲	UNPENDED	AMENDED		_							
8760, tificate bong physic as the bun	1	IF FEMALE: 23b. Was decedent pregnant in the	ne 23c. If yes,	outcome of pregnal birth	ncy 2 Feta	al death 3	Ectopic	pregnanc	у	23d. Date of Month	delivery Da	y Year
P.O. Box 687 s that the death certification by the attending p	Physician/Medical	past 12 months?	(DOLLD)	nant at time of death		er (Specify)				1		
D. B.	F	Part II. Other significant condit	9 Unkn		ulting in the un	derlying cause g	iven in Part	t I.	23e. Did to	bacco use contri	bute to th	e cause of death?
P.O.	ğ								1 Yes	2 No 3	Proba	bly 4 🗹 Unknown
ords, P w requires t w been sign should be c	Completed								24a. Was a			psy findings available mpletion of cause of
eco he law ate has	E			-		-			perfor		leath? Yes	2 No
ital Recieian: The scertificate rector, page	BeC	25. Was case referred to medica examiner?					of Death ((
F Vit	2	1 ✓ Yes 2 No		Inpatient 2 VE			other a			Residence 6 _	Other:	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	<u>ë</u>	27. Manner of Death 1 ✓ Natural 5 Pend		h, Day,Year)	8b. Time of Inj		es 2 []	- 1	du. Describe i	low injury occurr	eu	
riSiO	licat	2 Accident Inves	stigation	ce of Injury - At hom	e, farm, street						er or Rura	al Route Number, City
Division of Boylesion of Affending Ph. 24 hours after death. Funeral Director: After each filled in by the funeral	Certification:	Suicide	rmined (Specify						or Town, S	tate)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical (29a. Certifier 1 Certifying Plone) 2 Medical Exa	hysician: To the be miner:On the basis	of examination and	, death occurre /or investigation	ed at the time, da on, in my opinion,	te and plac death occ	e, and durred at t	ue to the cause he time, date a	e(s) and manner and place, and d	as stated ue to the	i. cause(s)
To wit	ğ.	29b. Signature and title of certifie	and manner	siated.		29c. License				29d. Date signe		
THE I		D-MUL				O.C.1	Λ.E.			September	1, 201	1
- 41	ı	30. Name and address of person		•		A/ D=14:	Ctus -t -) alt:	MD 24	222		
	110	Donna M. Vincenti, M 31. Date filed (Month, Day, Year)	A			vv. paitimore	orreet, l	oaitimo	ле, MD 21.			
Regist	:115 217	EP 0 6 2011 A	men 1	egistrar' Signature								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER 12 2011 CHARLES 7:00 p^{M} HENRY MOLONEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 120 Washington Ave. Kent Chestertown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 9 1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2 □ F 89 Pennsylvania 202-03-9245 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertal Hygelen. Insportant: If the 23 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "wident Exercities must be nuffilled at 1 XYes 2 ☐ No Director MD Kent Chestertown 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 120 Washington Ave. 21620 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Mayes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White 2 3 ☐ Widowed 4 ☐ Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 7. Ind Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farm Manager Thoroughbred Horses 12 Jih and Mental Hw 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Molonev Elizabeth McEntee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Doris L. Moloney (wife) Chestertown, MD. 21620 120 Washington Ave. 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kent Cremation Services 9/13/11 Smyrna, DE. 4 Donation 5 Dother (Specify) ^{22. Name and Address of Facility} Galena Funeral Home of Stephen L. Sci 118 West Cross St. Galena, MD. 21635 M00510 Approximate Interval Between Onset and Death Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ca. e (Final disease or a dition resulting in eath) **Physician** espiratory Failure /Medical Due to (or s a consequence of): Obstavilie Pulseonary **Examiner** DURNULL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine requires that the death certificate be executed TOBACCO ABUSE ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a Ö 1 ☐ Yes 2 ☐ No 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Des 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CON 24a. Was an After this certificate has autopsy performe page PULMonanz Hxpenteusion 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No of Vital Physician: 25. Was case referred to me if al examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? or Attending Division 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 223 High St. Chestertown, MD. 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jr., M.D.

32. Registrar's Signature

John C. Arrabal,

31. Date filed (Month, Day, Year) SEP 1 9 2011 9/13/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ rances Newman 2011 2:00 A.M.M September Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles County Nursing & Rehab Center Charles LaPlata 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min Maryland Yrs Director 82 217 32 3186 April 8 1929 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits

1 Yes 2 No 10a, State 10c. City, Town or Location Director Waldorf Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20601 13350 Poplarhill Road United States death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after Yes 2 X No Specify: Indian/Black If Yes, Give Year or Dates 1 ☐ Yes 2 XXNo Specify: 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Heath and Mental Hygiene. Important if item 27 is marked other than any injury or other transmit Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Henry Savoy Mary Marie Harley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Newman (Son) 13350 Poplarhill Road, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 9-12-2011 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery! Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria ture of Funeral Service Lie 21. Sign Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exam Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the 88 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 2 No Yes P.O. 23e. Did tobacco use contribute to the cause of death? <u>}</u> mtechon Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 After this certificate funeral director, pag 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 D No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injurv work? 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Aft
bleted filled in by the fur 2 🗌 No M Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 06/2011 30. Name and address offperson who completed cause of death (Item 23a) (Type, Print) dewates allow ny Drive i A, Annapolis, mo

Registrar
DHMH 17 Rev 7/2009

State

Redistrar's Signature

SEP U?

Registrar
DHMH 17 Rev 7/2009

State

ROBERT TIMOTHY PACE, M.D.

31. Date filed (Month, Day,

30. Name and address by person who completed cause of death (Item 23a) (Type, Print) 12070 OLD LINE CENTER, SUITE 302

32 Registrar's Signature

D 22574

SEPTEMBER 6, 2011

WALDORF, MARYLAND 20604 / P.O. BOX 249

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Manuel troctor 8:31 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington
If Under 24 firs. Washington For Prince g. Birthplace State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Social Security Number **Funeral** 1 X M 2 - F Months Days Hours Min (Month, Day, Year Washington DC 58 **Director** 0408 1952 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Tes 2 No Marzhanc Charles Valdor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2345 DAVIS 20603 items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 11. Marital Status 14. Race - American Indian, Black. White, etc. 9 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: . Page 1 and 2 should be filed within 72 hours aft ment of Health and Mental Hygiene. Latt if then 27 is marked other than "natural", jury or other traumatic event, the Medical Examing overnit, the Medical Examing the Medical Examination of the Medical Examination 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Board Elementary/Seconday (0-12) College (1-4 or 5+) Education Maintance 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Proctor Proctor John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE Waldorf 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Jusephi 4 ☐ Donation 5 ☐ Other (Specify) 9-11 Signature of Funeya Service Licenses 22 Name and Address of Facility MD 20608 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ardia Aron thon 1 a Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 6 ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of The law requires that the death certificate be executed the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical evious Division of Vital Records, P.O. Box 68760 as IF FEMALE asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day Pregnant at time of death page 2 should be detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been a porten 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certific. To the Funeral Director After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Investigation 6 Could not be ☐ Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RITUM D0028035 Sep 2, 2011 Pism ta Way Rd- #310 30. Name and address of person who completed cause of death (Item 23a) (Type, Print BASIRMOHMAD F. KOLI

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

6

32. Registrar's Signature

CLINTUN

mD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

iheila Perry		1- For State	ate of Maryl		epartment o Certificate o			Menta	al Hy			201		2979	92
Physicia	n/	1. Decedent's Name (First, Midd	le,Last)			-			- 1	2. Date of Dea Month	Reg. No. ath Day	Year	7	3. Time of Death	
Medical Examir	ıer	S1 4a. Facility Name (if not institution		Perry		4b. City, To			D. oth	Septemb	er 6, 20	O11 County of D		2242 hrs	
		Prince George's Hosp	. •	umber)		Cheve		ocation of	Deam		1	rince Ged		S ,	
Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	if Under	1 Year	if Under	24Hrs.	8. Date of B	irth (MM/I	rth (MM/DD/YYYY) 9. Bi		place (State or	
Director		577-80-0100	1 M 2 X F	5	3 Yrs	Months i.	Days	Hours	Min.	Jan.	15,		oreign Cour	ntry) DC	
A		Usual Residence of Decedent 10a. State 10b, County		1100 (City, Town or Local	ion							- 1	IOd. Inside City Li	mito
ilow any				100.	Sity, Town or Local	ION		Uaah:	inat	-on				1 X Yes 2	
Maryland 28a-f show d at once.	g	DC 10e. Street and Number				10f. Zip C		Wash:	Ingu		10g. Citiz	en of What			
th the Maryland 23a or 28a-f sho notified at once.	Director	4016 E Street	SE					200	019		-	Uni	ted	States	
n with	era Te	11. Marital Status	12. Was De	cedent Ever i						cify Yes or N	0-			an Indian, Black,	
r death w	Funeral		1 Yes	2 X N		es, specify	_		ueito r	(ican, etc.)		White, e		- 1-	
irs afte	<u>a</u>	3 Widowed 4 Div	orced If Yes, Give Ye or Dates: cify only highest gra		1 1d) 16a. Deceder	Yes 2			nd of wo	ork done		S <i>pecify:</i> ind of Busine		ack	
72 hou	Completed	Elementary/Secondary (0-12)		1-4 or 5+)	during m	ost of worki									
15-0036 filed within 72 I Hygiene. ad other than "	ᇍ		4			Youth	Cou	nselo	r			Gove	cnm	ent	
filed v filed v Hygi of oth		17. Father's Name (First, Middle,	,				18	3.Mother's		First, Middle,		-			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "matural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	To Be	J e 19a. Informant's Name/Relations	sse Perry hip (Type, Print)		19b. Mailin	Address	(Street a	and Numbe		rnesti ıral Route Nu			state. 7	Zip Code)	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	-	Ernest D. Gra	nt - Neph	ew		E Str				hingto			019	-,,	
re, land Healt Healt filter		20a. Method of Disposition 1 ABurial 2 Cremation	3 Pomoval f		Ob. Place of Dispos crematory or ot		of ceme			Date		ocation - Cit	y or T	own, State	
Pages		4 Donation 5 Other S		TOTT State		nony			Бері 16,	tember 2011	L	andove	er,	Marylan	d
Baltimore, permit. Pages 1 a Department of He Important: If ite		21. Signature of Funeral Service	() ()	7 th 3	2,	lame and A				ewart 1				Inc.	
Physician	4	23a. Part I. Enter the disease, or	complications that	4.						VE Was			DC	20019 Approximate Inte	erval
/Medical		failure. List only one cause Immediate Cause (Final disease	on each line.				, ,,							Between Onset a Death	
Examiner		or condition resulting in death)	Due to (or as		ce of):										
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequen	ca of):							-			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c											-:	
xecuted n and - transit		events resulting in death) Last	Due to (or as	a consequent	ce of):								Ĭ		
9 a a	odical	▼ UNPENDED	AMENDED	23a,27	,per me,	g919	9-28	-11 8	sm						
760, icate be physici		IF FEMALE: 23b. Was decedent pregnant in th		outcome of p	oregnancy			,			23d	. Date of del	ivery		
Box 6876(death certificate he attending physelor use as the b	ig.	past 12 months?	Live	birth nant at time o	f doath	tal death her (Specif)	3	Ectopic p	regnan	су	1	Month	Da	y Year	
BOy e death the atte	Physician/M	1 Yes 2 No 9 V Unk	9 Unkr	own	3 [] 01	ner (Specii)	" —				23/2				
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician has been signed by the attending physician has been signed by the funeral director, page 2 should be detached for use as the boundletely filled in by the funeral director, page 2 should be detached for use as the boundletely filled in by the funeral director, page 2 should be detached for use as the boundletely filled in by the funeral director, page 2 should be detached for use as the boundletely filled in by the funeral director, page 2 should be detached for use as the boundletely filled in by the funeral director, page 2 should be detached for use as the boundletely filled in by the funeral director.	P P	Part II. Other significant condit	ions contributing t	o death but n	ot resulting in the t	ınderlying c	ause giv	en in Part	i.					e cause of death?	
duires quires en sign						_			_	24a. Was				psy findings avail	
cords law requi	Completed							-		auto			to co	mpletion of cause	
tal Rec		25, Was case referred to medica					DI	. D 11. (O		1 Yes		1 🗸	Yes	2 No)
Vital hysician this cert	8	examiner?	Hospital:	Inpatient 2	✓ ER/Outpatient		10	f Death (C		Home 5	Resider	nce 6 C	ther:		
n of \ding Phy.	<u>'</u>	27. Manner of Death	28a. Date		28b. Time of I		c. Injury	at Work?	72	28d. Describe	how inju	ry occurred			
ttendi death.	cation	1 X Natural 5 Pend 2 Accident Inves		,, ,			1 Ye	s 2 N	lo						
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the Within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacted.	Certific	3 Suicide 6 Coul	d not be 28e. Plac		At home, farm, stre	et, factory, o	ffice bui	lding, etc.	2	28f. Location or Town,		nd Number o	r Rura	I Route Number, (City
Lospita Hours Luncra		29a. Certifier	nysician: To the be		dodgo, doath occur	rad at the fir	ma data	and place	and a	lue to the sau	100(c) and	d manner as	statos		
To the Ho within 24 h To the Fu	edical	,	miner: On the basis and manner:	of examination											
E > E 8	≗	29b. Signature and title of certifie		Autou.		29c. L	icense i	number			29d. [Date signed	(Mont	h, Day, Year)	
		mosz					D.C.M	.E.			Sep	tember 8,	201	1	
R		30. Name and address of person Ana Rubio MD. Ass	who completed cau istant Medical	,	,	imore Str	eet D	altimora	MI	21223					
Sta	te						eet, B	animore	, IVID	Z 1ZZ3					
Registr	21	31. Date filed (Month, Day Year)	Person	1. 1	nature sales										

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29,201et 7:30a August Physician/ Robinson Effie Loraine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring 11212 Markwood Drive 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Age (In vrs. last birthday) **Funeral** Ok Tahoma 1 M 2 1 Hours 7 124 94 94 9 443-20-9606 92 Director Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Spring 1 ☐ Yes 2 ☐ No Silver Md Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA Funeral 12212 Markwood Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death \ 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give ò 1 Never Married 2 Married Specify: Black Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Midowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Oklahoma City Police Dept. (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. College (1-4 or 5+) Elementary/Seconday (0-12) Clerk æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lizzie Malone Eli Rogan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11212 Markwood Drive Silver Spring, Md20902 Shirley Duncan/Niece 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Pilgrim Rest Cem. 9/08/2011 Oklahoma City, OK. 4 Donation Other (Specify) PHILIPADS RENALDI FUNERAL SERVICE, P.A. 21. Signature of 50 9241 Columbia blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cardiac arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Ener III denying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy
performed?

1 Yes 2 X No Io the nosmus after death.

Within 24 hours after death.

To the Funeral Director: After this certificate has to the Funeral Director. After this certificate has been aftered to the funeral director, page 2 s death? 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 1 ☐ Yes 2 🗷 No ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🎽 Residence 6 ☐ Other (Specify) ျ 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) Sept. 1, 2011 and title of certifier 29c. License number 29b. Signatur D0051650 Ì 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Yasmin Panahy MD 10810 Connecticut Ave. Kensington, Md 20895

State Registrar 31. Date filed (Month, Day, Year)

SEP 02 2011

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 10:55 Anandkrishna Thirumalai Raman August Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 2010 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Months Days Hours Min 1 X M 2 - F Vrs 1922 India Director 232-41-6010 89 July Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 1 Yes 2 X No Maryland | Montgomery North Potomac 10f. Zip Code 10g, Citizen of What Country? 23a (Funeral United States 11310 Coral Gables Drive 20878 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. 'natural", or 1 Never Married 2 M Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Asian Indian 1 Yes 2X No Specify. 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. I other than ⁴ Elementary/Seconday (0-12) College (1-4 or 5+) Tobacco Industry Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ? ပ T.S. Ananthakrishna Iyer Alamelu Ammal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 Ravi Raman, Son 11310 Coral Gables Drive, North Potomac, MD 20878 Department of He Important: If item any injury 20a. Method of Disposition
1 □ Burial 2 █ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 8/26/2011 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Monsee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a co sequence of): disease or condition resulting in death) Medical Examiner ritical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) END Share Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last physician the burial Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Month Day Pregnant at time of death signed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the lirector, page 2 s autopsy 1 Ves 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending М Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number D0067512 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Ctr Dr 9901 Bangalore MD

State

Registra

2011

130

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ROTHKA 2011 1111 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Havre de Grace Harford Harford Memorial Hospital 8. Date of Birth
(Month, Day, Year)
April 1, 1958 g. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🖫 F Hours Director 221-54-5753 53 Usual Residence of Decedent 10b. County 10d. Inside City Limits at 10c. City, Town or Location Director 27 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Examiner must be notified Perryville Maryland Cecil 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21903 7 Bay Circle Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Rita's Elementary/Seconday (0-12) College (1-4 or 5+) North East, Maryland Owner/Operator Twelve Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event James Harrell Lois Barr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a, Informant's Name/Relationship (Type, Print) 7 Bay Circle Drive, Perryville, Maryland (husband) James D. Rothka Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harford Memorial. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 09/03/11 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licer Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland

Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final silure Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? for Month Vear Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown been signed by the should be detached 1 ☐ Yes 24 9 ☐ Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>a</u>. Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: or Attending work? 1 Natural 5 Pending 2 🗌 No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu death. 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of certifier 3127 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pariso Munte De 19202 2600 lesgon seel 31. Date filed (Month, Day, Year, State SEP 0 6 2011 Registrar

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 5:55 P^{M} September Margaret Esther Richter Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Garrett Goodwill Mennonite Home Grantsville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F Months Days Hours Min Jan. 23, Year) 1916 Maryland 213-44-2136 95 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Accident Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a or event, the Medical Examiner must be a Funeral 31275 Garrett Hwy. 21520 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian. Was Decesco... Armed Forces? ⁴ □ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Mary Etta Cramer Albert N. Ringer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Frazee/Daughter 246 North Hammond St., Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Luth. Cem. Sept. 8, 2011 Accident, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee I a P.O. Box 275, Grantsville, MD 23a. Part 1. Er fer he disease, if complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heirt failure. List only one cause on each line.

Immediate Cause (Final disease, or ordition) Approximate Interval Between Onset and Dea Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the huria Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death signed by the 23e. Did tobacco use contribute to the cause of death? ş 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No discu 24a. Was an perform ntia this certificate • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural
2 Accid 28d. Describe how injury occurred inium 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

the

only one) 29b. Signati

nd title of certifie

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Box 68760

P.O.

Records,

Division of Vital

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16/8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1618 P M 2011 Joseph M. Stratton, Sr. August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 30 Months Days Hours Min Nov. 11, 1936 New Jersey Yrs. **Director** 158-24-2400 74 Usual Residence of Decedent 10b. County 10a. State Aucust at 10c. City, Town or Location 10d. Inside City Limits rector notified 28a-f 1 Yes 2 No Maryland Montgomery Germantown ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 22801 Ridge Road 20876 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 See 2 No 1954-Black, White, etc ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ■ No Specify: Specify: 3 Widowed 4 Divorced Completed 1957 White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 5 (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 District Sales Manager Insurance traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Preston Stratton Martha Dare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other tr Joseph M. Stratton, Jr./Son 22801 Ridge Road, Germantown, Maryland 20876 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Souls Cemetery Sept.2,2011 Germantown, Maryland 22. Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, MD 20872 21. Signature of Funeral Service Licensee anie 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailure respirator Ph_sician/ Medical resulting in death) Due to (ar as a consequence of): Examiner embolism pulmonar acute Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine cancer Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-transi tour Stage lung that initiated events resulting in death) Last and Due to (o) as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical discase chronic obstructive ulmonary Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy this certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Tes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 1 Natural Investigation Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) MA DOO 47386 28,2011 August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Rockville, Maryland 20850 Medical 9901 John, MD 31. Date filed (Month, Day, Year) 32, negistrar's Signature AHC 30 2011 Markal Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of M	arylan		artment of F <i>tificate of L</i>		and Mer				
			Registrar 1. Decedent's Name (Fi	irst, Middle, Las	t)		Cei	incate of L	Jeann	2.	Date of Deat	leg. No.2	+-	2 9 7 9 8 3: Time of Death
	Physicia Media		Willie	J. Scott						Se	Month eptembe i	r 5, 2011	ear	5:35 A M
đ	Examir	ner	4a. Facility Name (if not					4b. City, Town, or		of Death	1924-1-1-1	4c. County of		•
-	Funeral		5. Social Security Numb	per 6. Se		e (In yrs. la	st birthday)	Clint If Under 1 Year	On If Under	24 Hrs. 8.	Date of Birth	Prince		'ge's lace (State or Foreign
	Director		258 54 1123		X M 2 □ F	73	Yrs.	Months Days	Hours	Min. No	(Month, Day, OV 4, 19	937	Count	jia
	nd how at]	Usual Residence of Dec 10a. State 10	cedent b. County		10c. City	, Town or Loc	cation					11	Od. Inside City Limits
	Maryla 18a-f s rtified	rect	Maryland F	Prince Geo	rge's		Clinton							1 🗆 Yes 2 🗓 No
	h the la or 2 be no	a Di	10e. Street and Number					10f. Zip Code				10g. Citizen of Wha		try?
	ath wit	uner	9508 Bever	rly Ave	12. Was Decedent E	ver in LLS	12 1/	2073		ain? (Specify)	Voc or No	United Sta		
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 Never Married 3 Widowed 4		Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates.		If	Vas Decedent of Hi Yes, specify Cuba	n, Mexican	, Puerto Rica	n, etc.)		Mhite, e	tc.
15-(72 hou n "nat ledica	nple		 Decedent's Ed only highest gra 			(Give k	ent's Usual Occup	ation <i>luri</i> ng most	of working		16b. Kind of Busin	ess Ind	lustry
212	within giene.		Elementary/Seconda	ay (0-12)	College (1-4 or 5	+)		NOT use retired) Driver			İ	Transporat	ion	
pu	filed tal Hyg	To Be	17. Father's Name (First									Maiden Sumame)		
Maryland	d Men marke matic	-	Farnest 19a. Informant's Name/		n - Ouint)		ī			Ella J	101			
Ma	and 2 should be filed within 73 Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the Me		Rosa Scott		se, Printi)		I i	g Address (Street a Beverly Ave				City or Town, State), Zip C	ode)
Baltimore,			20a. Method of Disposit		Removal from State	20b. Pl	ace of Dispos	sition (Name of place		Date		20c. Location - Cit	y or To	wn, State
tim	mit. Page ' partment or portant: If injury or		4 Donation 5 D	Other (Specify)	Line	oln Mem	orial Garde	ens 9	-10-201		Suitland,		
Bal	permit. Page Department of Important: If any injury or		21. Sign Ture of Funeral	cal	more	555 De		Ferry Road,	Clint	con, MD	20735		33 01	ld Alexandria
			23a Part 1. Enter the d shock, or heart fai Immediate Cause (Fina	ilure. List only on	e cause on each line									Approximate Interval Between Onset and Death
ð	Ph _{sician/} Medical		disease or condition resulting in death)	_	a. Black Due to (or as a			a with	Res Alm	lung 9	fui hm	-	-	Onset and Death
	Examiner	L	Sequentially list conditi	ione	h									
	sit d	Examiner	if any, leading to immed cause. Enter Underlying	diate g	Due to (or as a	consequ	ence of).							
	xecute n and al-trans	Exar	Cause (Disease or iinjui that initiated events resulting in death) Last		c. Due to (or as a	ı consequ	ence of):						+	
00	cate be executed physician and the burial-transit	edical			d								\perp	
68760	rtificat ing ph e as th	/Mec	IF FEMALE:	1										
Box 6	eath certifica attending p	Physician/M	23b. Was decedent preg in the past 12 mont	ths?	3c. If yes, outcome of 1 ☐ Live Birth : 4 ☐ Pregnant at	2 🗌 Fetal	death 3	Ectopic pregnanc	у			23d. Date o Month		ry Day Year
O. B	that the dea ned by the a detached f	hysi	1 Yes 2 No		9 🗌 Unknown			(3,744.1)/						
ds, P.O.	requires that been signed should be det	by	Part II. Other significan achte hi End Staye	lateral	In few to	U CCU	ilting in the ur	nderlying cause giv	en in Part I.			pacco use contribu		e cause of death?
Division of Vital Records,	law has e 2	Completed	End Stage	Rend D	iscare in	. Her	wiha	lying			24a. Was ar autops perform 1 \(\subseteq \text{Yes} \) 2	y prio ned2 dear	r to con	sy findings available inpletion of cause of
tal	ician: The certificate rector, pag	Be	25. Was case referred to examiner?	4	lospital:					h (Check only		T JON CH		
ž.	Physi r this c	٠ ا	1 Yes 2 No	0	1 In hpatie		R/Outpatient 28b. Time of	28c. Injury	4 ∐ Nu	-		ence 6 Other (S	pecify)	
o uc	nding ath. r: Afte ie fune	icate		Pending Investigation	(Month, Day,	Year)	injury	work'		ı	Describe no	w injury occurred		
ivisi	il or Atte after de Directo	Certificate:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Inju- building, etc.		ne, farm, stre	et, factory, office			Location (Str City or Town,	reet and Number o. , State)	Rural I	Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	(Check 2 □ M	Medical Examin	cian: To the best of rer: On the basis of exercioner: To the basis	amination	and/or investi	gation, in my opinio	n, death occ	curred at the t	ime, date and	d place, and due to	the caus	se(s) and manner stated.
	To th withir To th comp	2	29b. Signature and the o		1	. Tot of my	omouge, u	29c. License		and piace, dil		9d. Date signed (M		
			Mail	Mhi	MIZ			D000	5/20)	5	september	5	, 20 i)
B	B2		30. Name and address of	1	mpleted cause of de	eath (Item)	23a) (Type, Pr M WK	int) we SE Shu	te 31	D Was		/	32	
-	Stat Registra		31. Date filed (Month, Da	SEP U7	20 1 32. Registral			bank			/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Physician/ 11:00A Joseph Sanders, Jr. Nathaniel 29 Aug Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Fort Washington Prince George's Fort Washington Hospital 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Hours **Director** 70 Memohis. Tenn 326 34 9796 June 27 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 📉 No Fort Washington Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 20744 United States 9410 Dashia Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Waş Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 Yes 2 No 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Lockheed Martin Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Doris Burt Nathaniel Joseph Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9410 Dashia Drive, Fort Washignton, MD 20744 Bernice L. Sanders (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 9-12-2011 4 Donation 5 Other (Specify) Cheltenham, MD Marvland Veterans Cemeteriv 22. Name and Address of FacilityLee Funeral HOme, Inc 6633 Old Alexandria Signatury of Fun S Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph sician/ therosilevoti disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or linjury Day to for swa nonsequence off Exami the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of Blood s certificate has b lirector, page 2 st autopsy performed? Yes 2 \Box 1 ☐ Yes 2 ☐ No in 24 hours after death.

The Funeral Director: After this certifical pleted filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 □ Yes 2 □ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 005605 and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

Dr. Arvind Narasimhan, 11711 Livingston Road, Fort Washington, MD 20744-5164

Please Type or Print in Black Indelible Ink. Fnsure All Copies Are Legible. Amend 17 per FH G919 9/20/1 Fnsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 2011 SYLVESTER SMITH 3:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS HEALTHCARE WALDORF CENTER CHARLES WALDORF if Under 1 Year 5. Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Sex 1 **X** M 2 □ F Months Days Hours Min JULY 17, 1930 579-38-9122 81 WASHINGTON.D.C. **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MARYLAND CHARLES LA PLATA 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20646 UNITED STATES 7545 ANNAPOLIS WOODS ROAD hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mee once. Elementary/Seconday (0-12) College (1-4 or 5+) 9TH GRADE FEDERAL GOVERNMENT RIGGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ANTHA PRYOR EZELL UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7545 ANNAPOLIS WOODS ROAD, LA PLATA, MARYLAND 20646 PEARL SMITH / WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State SMITH CHAPEL CHURCH CEM. SEPT. 10,2011 PISGAH, MARYLAND 4 Donation 5 Other (Specify) LYDIA C. THORNTON JOHNSON MO0583 THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final HROWI Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examine Kal Sequentially list conditions ri any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine 0 requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Month Day Pregnant at time of death 1 Yes 2 9 Unknown detached Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pe 1 Yes 2 No 3 Probably 4 Vinknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law I has autopsy perforn Yes 2X No certificate Physician: Vita Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **X** No ပ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. this of Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 5 Pending Division Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartifying Nurse Fractionen To the best of my knowledge, death of d at the time, date and place, and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 20629 SEPTEMBER 6, 2011 s of derson who completed cause of death (Item 23a) (Type, Print) $11345\,$ PEMBROOKE SQUARE, SUITE $103\,$ WATHEN, M.D. GEORGE H WALDORF, MARYLAND 31. Date filed (Month, Day, Dav. Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Schultz 15 13 Glenn Louis 011 01 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 🕱 M 2 🗆 F Months 10-18-1940 70 Director 216 38 7770 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 No Howard Ellicott City MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21042 United States 10306 Spruce Way 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 0 ģ 1 Never Married 2 😾 Married 1 X Yes 2 □ No
If Yes, Give
Year or Dates. 1963–64 Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: Completed 3 Divorced 4 Divorced White Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Home Improvement Carpenter of Health and Mental Hygie If item 27 is marked other ir other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eunice Irene Phillips Grady Louis Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 i 10306 Spruce Way Ellicott City, MD 21042 Katherine Schultz/Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of Important: If i any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Crest Lawn Mem. Gard. 9-7-2011 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ neumonia disease or condition resulting in death) Medical Due to (or s a consequence of: **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 Yes 2 Wo Yes 2 N 25. Was case referr to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SEP 0 6

Box 68760 P.O. of Vital Records, Division

To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be

Be

၉

Certificate:

Medical

25. Was case referred to medical

2 No

5 Pending

Investigation 6 Could not be

determined

examiner?

27. Manger of Death

1 🖾 Natural

2 Accident
3 Suicide

4 Homicide

29a. Certifier

(Check unhi c

13 State Registrar

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0051429 August 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Dr., #224, Olney, Md. 20832 Cynthia Chrosniak, M.D. 31. Date filed (Month, Dev., Year) 3 Fiegistrar's Signature 201 Parana.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at

work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying harves Practioner: To the basis of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner as stated.

26. Place of Death (Check only one)

2 No

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

City or Town, State)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

28a. Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:05 AM Murray 2011 August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth g. Birthplace (State or Foreign Birthpiac Country) NY 5. Social Security Number **Funeral** 1 M 2 □ F Months Days Hours Min. 07/01/1929 82 Yrs Director 060-22-8374 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a, State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MONTGOMERY SILVER SPRING MD 10f. Zip Code 10e Street and Numbe 10g. Citizen of What Country? Funeral 2901 20906 USA SOUTH LEISURE BLVD., #506 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 □ No1 946 - Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: WHITE Year or Dates. 1951 Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry al Hygiene. I other than " JOURNALIST Elementary/Seconday (0-12) College (1-4 or 5+) NEWSPAPER 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ဂ္ LETA AMSDELL CARL SEEGER should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is 20 BARLEY FIELD CT., DICKERSON, MD 20842 STEVE SEEGER / SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State STAUFFER CREMATORY 08/31/201 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Selvice Licensee P.O. BOX 86 22. Name and Address of Facility HILTON FUNERAL HOME BARNESVILLE, 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ neecmonia Medical Due to (or as a consequence of) Examiner pulmonary f. brosis Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 🗌 No 1 🗌 Yes Yes filled i by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No ဂ္ 1 🗌 Yes 1 N Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours are death. To the Funeral Director After th completed filled in by the funeral Medical Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 \square Pending M Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D61624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YUANJUE ZHANG MD PRINCE PHILIP DR., OLNEY, MD 20832 1.8101 egistrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

11-05509 Delithia Shephard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician/ Physician/ Decedent's Name (First, Middle, Last) Shepherd Shephard	2. Date of Death Month	h	
	July 23, 20	Day Year)11	3. Time of Death 2304 hrs
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De Route 5 and Surratts Road Clinton		4c. County of Death	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	1.0	h(MM/DD/YYYY) 9. Bird	thplace (State or
Director 577-02-7407 1 M 2KF 38 Yrs. Months Days Hours Usual Residence of Decedent	Min. Feb. 6		untry) DC
10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland Prince George's Suitla Suitl		g. Citizen of What Cour	1 X Yes 2 No
Maryland Prince George's Suitla Suitl		United S	tates
11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? 15. Was Decedent of Hispanic Origin? 16. Yes, specify Cuban, Mexican, Pue		14. Race - Ameri White, etc.	can Indian, Black,
3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind	of work done	Specify: B1a	
Elementary/Secondary (0-12) 12th College (1-4 or 5+) Supply Director			·
	ame (First, Middle, M		vate
Reginald Shepherd 19a. Informant's Name/Relationship (Type, Print) a her 19b. Mailing Address (Street and Number)	Delores		Zin Codo\
Reginald E. Shepherd Sr 4211 12th Street NE	Washingt	on, DC 200	017
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee's Crematory 2 crem	ept ^{Date} 9, 2011	20c. Location - City or	Town, State Maryland
21. Signature of Funeral Service Ligensee 22. Name and Address of Facility St	tewart Fur	neral Home,	Inc.
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial		-	20019 Approximate Interval
failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Blunt Force Injuries			Between Onset and Death
or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
events resulting in death) Last Due to (or as a consequence of):			
Description of the past 12 months? d. Comparison of the past 12 months Compariso			
The Females of Pregnant of Pregnancy 1	gnancy	23d. Date of delivery Month D	ay Year
23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 1 Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.			
By By By By By By By By By By By By By B		pacco use contribute to to 2 No 3 Prob	
The second of th	24a. Was ar autopsy	y prior to co	opsy findings available ompletion of cause of
THE TOTAL PROPERTY OF THE TOTAL PROPERTY OF	perform 1 Yes 2	ned? death? No 1 ✓ Yes	s 2 No
25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nur		tesidence 6 🗸 Other:	Scene
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending 1 Ves 2 No 1 Yes 2 No		ow injury occurred xed object collision	n
To start the start of the start		reet and Number or Rur	
Pending Specify Post Specify Specify Post		ate) urratts Road, Clinton, (s) and manner as state	
29a. Certiffier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a converge of the convergence of		nd place, and due to the 29d. Date signed (Mon	
		July 24, 2011	, 229, . 001/
O.C.M.E.	1		
30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore S	timore, MD 2122	23	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Edward Taylor August 1:00a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Citizens Care and Rehab. Center Frederick Frederick If Under 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign
 Country) **Funeral** 7. Age (In yrs. last birthday) (Month, Day, Year) 920 1 ☎ M 2 ☐ F Months Days Hours Min. **Director** 082-12-2288 90 Dec. Connecticut Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified 1 X Yes 2 □ No <u>Maryland</u> Frederick Frederick ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1900 Rosemont Avenue 21702 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗆 No WWII Black, White, etc. þ 1 X Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1942–46 1 ☐ Yes 2 X No Specify Specify: 3 Divorced 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Lithographer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Andrew Jackson Taylor Isabelle Theresa Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Rudolph D. Anzalone Jr./Nephew 8400 River Meadow Drive, Frederick, Maryland 21704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 9/2/2011 Mt. Frederick, Maryland 21. Signature of Funeral Service Lices \$22. Name and Address of Facility \$1621 Opossumtown Fike, Prederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Fith Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the huneral director, page 2 should be detached for use as the burlar-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been si funeral director, page 2 should I 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Anatural 5 Pending Accident Investigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 100 61410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dx, TOLL HOUSE FAR SYEI REDERICK MD

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 29807 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav George Washington Trainum, III 11:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly 9. Birthplace (State or Foreign Social Security Numbe If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🛣 M 2 🗆 F Months Days Hours Min Washington. Director 217-32-3770 July 75 Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5101 Upshur Street 20710 USA 1 and 2 should be filed within 72 hours after death v f Health and Mental Hygiene. item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗆 No Army Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 X No Specify. Ves Give Specify 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Tax Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Washington Trainum, Jr. Doris Talley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy S. Trainum / Son 5423 Ladue Lane, Fairfax, VA 22030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1; 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 9/7/2011 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Ja Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U. Johnny Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) ACIOU 813 and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the t IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate Peornic and Property of the Puneral Director. After this certificate Peornicleted filled in by the funeral director, page 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မှ 1 X Inpatient 2 A ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Tsion Berhane, 3001 Hospital Drive, Cheverly, Maryland 20785

Registrar's Signatur

September 3, 2011

11-06760 • Steven A. Tilley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

to voir 7t. Time,		1- For State Registrar	Certi	ificate of De			201 Reg. No.	1 2980
Physic		Decedent's Name (First, Middle,Last)	illov			2. Date of Dea	ath	3. Time of Death
ledical Exam	inei	Steven Arthur T 4a. Facility Name (if not institution, give stre	_	4b. Cit	y, Town, or Locat		er 7, 2011 4c. County of Death	1447 hrs
		31 Village Circle	,		nton	7, 3, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2,	Caroline	•
Funeral Director		5. Social Security Number 217-76-6279 Usual Residence of Decedent	7. Age (In yrs. last				irth(MM/DD/YYYY) 9. Bir 8, 1958 Foreig Co	
any		10a. State 10b. County		own or Location				10d. Inside City Limits
Aaryland 28a-f show I at once.	ğ	MD Carolin	1e	Dento				1 XYes 2 No
th the Mary 23a or 28a notified at	Il Director	10e. Street and Number 312 Village Cou:	rt	10f. :	Zip Code 2	1629	10g. Citizen of What Cour United St	-
er death wi	Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? Yes 2 X No	If Yes, spe	cify Cuban, Mexi	Origin? (Specify Yes or Nocan, Puerto Rican, etc.)	White, etc.	can Indian, Black, White
urs afte tural?	d by	3 Widowed 4 X Divorced If Yes or Date 15. Decedent's Education (Specify only high	ates:	6a. Decedent's Usu		ive kind of work done	Specify: 16b. Kind of Business/I	ndustry
1036 vithin 72 ho ene. er than "ua	Completed		College (1-4 or 5+) 5 +		vorking life, DON .ngemen	OT use retired)	Dept. of Na Resour	atural
21215-0036 21215-0036 Mental Hygiene. marked other than	B	17. Father's Name (First, Middle, Last) Guy A. Tilley			В	her's Name (First, Middle, etty L. Ki	ng	
MD 2's should alth and Man 27 is man and man and man and man and man and man and man and man and and and and and and and and and a	욘	19a. Informant's Name/Relationship (Type, F Guy A. Tilley/F	ather	4314 Bl	inkhor	Number or Rural Route Nu n Road, Hu	rlock, MD	21643
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens and Comparation of Health and Mental Hygiens and Comparation of Health and Mental Hygiens 23a or 28a-fahe injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 X Cremation 3 Re 4 Donation 5 Other Specify:	emoval from State cre	erce of Disposition (Nematory or other place) -Shore Ci	ce)		20c. Location - City or Cambridge,	
Balt permit. Departu Import		21. Signature of Funeral Service Licensee Muleul J. Gallew		216 1		St., Federal		P.A. 1632
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each line	ns that caused the death. Death.	o not enter the mod	e of dying, such a	is cardiac or respiratory and	rest, shock, or heart	Approximate Interval Between Onset and
zaminer			atty Liver and of (or as a consequence of):	d Early I	iver Ci	rrhosis		Death
	_	Sequentially list conditions, b						
s:e	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	o (or as a consequence of):					
cuted und transit	l Examiner	events resulting in death) Last Due to	o (or as a consequence of):					
60, ate be exe hysician a	Medical	X UNPENDED X AME	ENDED 23a,pt.I 5 per f	I,27 per h 9922 12	me_g920 -27-11	10-13-11 vt		
Division of Vital Records, P.O. Box 68760, To the Bospial or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnar Live birth Pregnant at time of death	ncy 2 D Fetal deat	h 3 Ecto	opic pregnancy	23d. Date of delivery Month D	ay Year
BO he deat the at hed for	hys	1 Yes 2 No 9 Unknown g	Unknown					
, P.O. res that the signed by be detach	þ	Part II. Other significant conditions control Chronic Alcoholi		ulting in the underly	ng cause given in	Part I. 23e. Did to	obacco use contribute to to s	he cause of death? ably 4 Unknown
ords w requi	Completed					24a. Was autop	osy prior to co	opsy findings available ompletion of cause of
Rec The la icate h	E					1 ✓ Yes	rmed? death? 2 No 1 ✓ Ye	s 2 No
ital ician: s certif rector,	æ	25. Was case referred to medical examiner?	#:4	R/Outpatient 3	Othor	th (Check only one)		
of V ig Phys fler thi neral di	٢ ا	1 ✓ Yes 2 No 27. Manner of Death 28		8b. Time of Injury	DOA Ottlei4 28c. Injury at W		Residence 6 Other:	Scene
ion ttendir leath. ttor: A	atior	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		1 Yes 2	No		
Division of Vital Records, piral and a require or Attending Physician: The law require our safer death. eral Director: After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be	8e. Place of Injury - At home Specify)	e, farm, street, facto	ry, office building	etc. 28f. Location (5 or Town, S	Street and Number or Rur State)	al Route Number, City
Division of Vital To the Hospital or Attending Physiciau: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical (one) 2 Medical Examiner: On th	o the best of my knowledge, se basis of examination and/ manner stated.					
	Ž	29b. Signature and title of certifier	· ,	2	G. License numb	er	29d. Date signed (Mon	
rk et		30. Name and address of person who comple	ing Th.	u. D.	O.C.M.E.		September 8, 201	
Ψ			eted cause of death (Item 23) Assistant Medical Exa		/. Baltimore S	Street, Baltimore, MD	0 21223	
St Regist		31. Date filed (Month, Day, Year) SEP 1 9 2011	32. Registrar's Signature	Ked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

riease	Type or Frint in Black indelible link. Ensure All Copies Are Leg
	State of Manyland / Department of Health and Montal Hygiana

ictor Noel VVIII		1- For State Registrar	Sta	ate of Maryland		artment of <i>rtificate</i> of			wentai		Reg. No.	201	1 2980
Physici Modical Exam	ian/	1. Decedent's Name		williams						2. Date of De Month Septemb	Day	Year 2011	3. Time of Death 0802 hrs
			f not institution	n, give street and number))		•	own, or Lo	ocation of De		4c.	County of Death	
Funeral Director		5. Social Security N	lumber (6. Sex 7. Ag	ge (In yrs. la	last birthday)	Months	_	If Under 24 Hours	4Hrs. 8. Date of B	•	DD/YYYY) 9. Birti Foreigi L958 Cou	
*us		Usual Residence of 10a. State			T10c. City	, Town or Locat							10d. Inside City Limits
B .H	5	MD		tgomery		ensingt							1 Yes 2 No
with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Nur					10f. Zip (Code 2089.	E		10g. Citiz	en of What Coun	itry?
with the ms 23a c		2913 Per 11. Marital Status		12. Was Decedent				t of Hispa	inic Origin?	(Specify Yes or N			can Indian, Black,
or ite	by Funeral	1 X Never Marrie 3 Widowed	4 Divo	1 Yes 2 orced If Yes, Giva Year or Dates:	X No	1	Yes 2	¥ No s	specify:	ierto Rican, etc.)		White, etc. Whit Specify:	
61 3		15. Decedent's Ed Elementary/Seco		ify only highest grade con College (1-4 or		during m	nost of work	ing life. Do	O NOT use			ind of Business/Ir	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (Eiret Middle I	2		Skil	Lled (ker		Woodwork	ing
21215-00; ould be filed with I Mental Hygiene i marked other t	Be C	Louis B	ier Wil	lliams, Sr.				10.		een Corr		Surriame)	
MD 21215-0036 12 should be filed within 7 th and Mental Hygene. a 27 is marked other than tumatic event, the Medica	ပ္	19a. Informant's Na		nip(Type,Print) liams, Sr./E	Fathe		-	•		or Rural Route Nu Kensing		-	
2 2 2 2		20a. Method of Disp 1 Buriat 2	oosition XXremation	3 Removal from Sta	20b. f	Place of Dispos crematory or oth ropolit	sition (Name ther place)	e of cemet	tery,	Date Sept. 12	20c. L	ocation - City or	Town, State
Baltimore, permit. Pages I as Department of Hee Important: If ite		4 Donation 5 21. Signature of Fu			TIEC	144	Name and A	Address of	tFacility 11	2011 ns Funera	al Ho	ome Inc.	
の No A A A A A A A A A A A A A A A A A A	-	23a. Part I. Enter th	e disease, or c	complications that caused	the death								ng, MD 20901 Approximate Interval
xaminer	1	failure. List [®] onl Immediate Cause (I	Final disease	_{a Multiple}									Between Onset and Death
· sat AT		or condition resulting		Due to (or as a conse	equence of	ਗੇ): 							
	Examiner	if any, leading to im cause. Enter Unde (Disease or injury the	mediate rlying Cause	Due to (or as a conse									
ecuted and and ransit		events resulting in		Due to (or as a conse	equence of	of):							
60, nte be execut nysician and	fedical	X UNPENDED		☐ AMENDED 23a			er me	,g919	9-30)-11 sm			
U = c o	an/M	IF FEMALE: 23b. Was decedent past 12 months		L CIVE DITAL		2 Fe	etal death	3	Ectopic pre	egnancy		I. Date of delivery Month D	v Day Year
Box 687 (e death certifice the attending pleed for use as the	Physician/N	1 Yes 2 N	lo 9 🗌 Unkn	1 Pregnant at 1 Unknown	time of ae	eath 5 Ot	ther (Speci	fy)					
P.O. es that the igned by oe detach	ð	Part II. Other signif	icant condition	ons contributing to death	h but not re	esulting in the u	underlying (cause give	en in Part I.			No 3 Prob	the cause of death?
ords, P.C w requires that as been signed 1 should be deta	Completed										psy	prior to c	topsy findings available completion of cause of
tal Recc cian: The lar certificate ha	Com		· · · · · · · · · · · · · · · · · · ·					C Disco of	- 11- /Ch	1 ✓ Yes	formed? 2 No	death? 1 ✓ Ye	es 2 No
	o Be	25. Was case referr examiner? 1 ✓ Yes	red to medical	Hospital: 1 Inpatie	ent 2 🗸	ER/Outpatient		104	han —	eck only one) ursing Home 5			;
드 를 그 ^ 43	ion: T	27. Manner of Death 1 Natural		28a. Date of Inju (Month, Day,Y	Year)	28b. Time of I	· ·	8c. Injury a	at Work?	28d Describe			by vehicle
Division pital or Attendion ours after death. neral Director: /	Certification:	2 X Accident 3 Suicide	Invest	tigation 10 9-10 28e. Place of In			5 am			28f. Location or Town,	State) SI	B Georgia	ral Route Number, City a Ave. at
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	4 Homicide 29a. Certifier (Check only one) 2	Certifying Phy	yslcian: To the best of miner: On the basis of exam	y knowled	ige, death occur and/or investiga	rred at the t	ime, date	and place,	Windhan and due to the cau red at the time, date	use(s) and	Wheat of manner as state ce, and due to the	ed.
	Mec	29b. Signature and		and manner stated.				License n	number		29d. D	Date signed (Mor	nth, Day, Year)
PEND		20 Name and addr.	ore of person v	who completed cause of d	dooth (Item	- 23a)		O.C.M.	E.		Sept	tember 11, 2	011
		Donna M. V	incenti, MD	Assistant Medic	cal Exan	miner 900	W. Balti	more S	treet, Ba	altimore, MD 2	1223		
S Regis	tate		" T'3°20	2. Registra	ır's Signatu	hark	1						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26^{Day} 2011 ear 9:00 P. Charles Drainie Watson August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 6397 Overbrook Circle Frederick Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav **Funeral** 1 M 2 D F Hours Min Country) 03/17/1940 **Director** MD 220-36-1730 71 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland must be notified at Director 1 Yes 2 No Millsboro DE Sussex 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 32196 Robin Hood's Loop USA 19966 items ? Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. iant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black White etc. 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed filters for an and Mental Hygiene.

27 is marked other than "natural for a marked other than "natural for a marked other than "natural for a marked White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) restaurant restaurantier Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Drainie Bergan Watson Mildred Viesman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Watson, II/son Bidle Hill Ct., Myersville, MD 21773 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 08/31/2011 | Frederick, MD Mt. Olivet 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. :15 Opossumtown Pike, Frederick, MD 1621 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown 2 No the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director. After this certificate to completed filled in by the funeral director, page Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? former wite home 6 M Other (Specify) Other: 4 Nursing Home 5 Residence 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 8 29

Registrar

0

State

31. Date filed (Month Pay,

Darkel

Diane Ruckert, CRNP, 516 Trail Avenue, Frederick, MD 21701

32 Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mary Suzanne Williams 28, 2011 1647 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 25, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 □ M 2 X F 393-34-8125 Wisconsin 74 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Evantmer must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No Director Aberdeen Harford Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21001 U.S.A. 700 West Bel Air Avenue, Apt. 430 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: δ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Arizona State University Elementary/Secondary (0-12) College (1-4or 5+) Tempe, Arizona Switchboard Operator Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Jo Christensen Edward Lentz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21904 25 Shire Lane, Port Deposit, Maryland Christopher Williams (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition West Chester, 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State R.A.Ferris & Co., Inc. 08/31/11 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania ^{22. Name and Address of Facility}
Lee A. Patterson & Son Funeral Home,
Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be execu burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☑ No. 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) detached 9 Unknown Atter this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 🗷 No 1 □Yes 🏖 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📈 No Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed ca

DHMH 17 Rev 1/2001

300

0

Williams

em 23a) (Type, Print)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Williams Physician/ Sept. Medical 4a. Facility Name (if not institution, give street and 4c. County of Death Examiner baltimore en If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number
 235–96–5016 7. Age (In yrs. **53 Funeral** (Month, Day ec. 15 1957 West Virginia 1 XM 2 X F Hours Year Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the file 23a or 28a-f sho antt. If item 27 is marked of other than "natural", or items 23a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State Director WV Mineral Keyser 1 Yes 2XXNo 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 278 Poplar Drive 26726 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Bace - American Indian. Armed Forces?

1 Yes, 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1975 ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1979 Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Electrician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jewell မ Woody Mangold Janet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
278 Poplar Drive, Keyser, West Virginia 26726 Debbie Williams/ wife 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ★ mation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 109/06/2011 permit. Page Department Important: If any injury or Cumberland Maryland . Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home 6 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Preumonio disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner espirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Esophagea Cause (Disease or iinjury concand that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death page 2 should be detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No cancer 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 \square Yes 2 ER/Outpatient 3 DOA 1 Inpatient After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and tit Mansour

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mans

31. Date filed (Month, Day, Year)

DUV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 28,2011 Curtiss Mae Glover Young 4:55p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days Hours 239-98-3693 55 647304 1956 CMntrc. **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Edgewood 1 Yes 2 No 10e. Street and Number r items 23a or liner must be n ö 10f. Zip Code 10g. Citizen of What Country? Funeral 421 Winterberry Drive 21040 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, event, the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James William Glover Jo Ella Darity injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si permit and 1 health at perpetrant If item 27 is any injury or other trau once. Shawn R. Young/Son Winterberry Drive Edgewood, Md. 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🖾 Removal from State Ebenezer Cemetery 9/03/2011 4 ☐ Donation 5 ☐ Other (Specify) Hendersonville, N.C 21. Signature of F ra Service Licensee PHILIP OF RINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition **CEREBROVASCULAR** Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) and -trans resulting in death) Last Due to (or as a consequence of) sician a burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? the Hospital or Attending Physician: The law requires that the death Pregnant at time of death Month Day Year Yes 2 X No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred injury (Month, Day, Year) 1 X Natural 5 Pending Accident Investigation M 1 Yes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit 29c. License number 29d. Date/signed (Month, Day, Year) 3 2011

State

Registrar

30. Name and ad

JACKIE JONES,

SEP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

CRNP

02 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) a_M 14, 20^{rea} Physician/ Arthur John Anders 9:45 Sept Medical 4b. City, Town, or Location of Death Olney4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery General Hospital Montgomery Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Funeral Min. Days (Month, Day,) 283-10-1358 **X** M 2 □ F OH **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 No Silver Spring MD Montgomery Citizen of What Country? 0f. Zip Code 10e. Street and Number USA 20905 Funeral 1900 Armond Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces ģ 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 🔀 No Specify:White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3¥☑¥Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Private Practice Social Worker 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) Clara Klein 17. Father's Name (First, Middle, Last) Arthur Anders ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 Oxhorn Ct. East Homosassa, FL 34446 Judy M. Koch, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 X Cremation 3 Removal from State Chesapeake Crematory 9/21/2011 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signal of Funeral Serv 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical quence of Due to (or as a cons Failure Examiner Sequentially list conditions, if any leading to incrediate cause. Enter Underlying Examine Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death n signed by the at Id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 After this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 1 🗆 Yes 2 🗖 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗀 No Investigation Accident Suicide 6 🗆 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 201 ath (Item 23a) (Type, Print

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 18, Year 2011 Rosa Maria Alfaro 5:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Sept 10, Davs Hours Min 1941 El Salvador Director 213-98-8344 70 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11215 Troy Road 20852 USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2X No Black White etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1X Yes 2 ☐ No Specify: Yes. Give Specify: White 3 🛮 Widowed 4 🗆 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) - snould be filt th and Mental h 18. Mother's Name (First, Middle, Maiden Surname, ဂ Jesus Granados Rosa Maria Castro permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marks any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11215 Troy Road Rockville, MD 20852 Allison M. Alfaro/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 09/20/11 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral S Ging Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville. _MD_21029 Part 1. Enter the Asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart falure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Gastric Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (unsease or impury Examine Due to (or as a consequence of) requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Tetal death in the past 12 months?
1 ☐ Yes 2 🔀 No for Month Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown been 24b. Were autopsy findings available prior to completion of cause of death? the Hospital or Attending Physician: The law page 2 certificate has autopsy performe 1 ☐ Yes 2 X No 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: $_4$ \square Nursing Home 5 \square Residence 6 \bigcirc Other (Specify) hospice 2 🔀 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work' within 24 hours after death. To the Funeral Director: Al 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

State

Bindu C.

31. Date filed (Month, Day SEP 2

DV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph, M.D.

D60634

6001 Muncaster Mill Rd. Rockville, MD 20855

September 18, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 29816 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2011 3. Time of Death 2. Date of Death Day Physician/ Month 825 PM Darrell ~ Fifteen Septembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A BaHMOre ood Scherite If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🛣 M 2 🗆 F Days Hours Min Months 48 4/29/1963 Director 217-84-2063 Yrs MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🙀 Yes 2 🗌 No MD N/A Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21218 USA 1504 Ralworth Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1X Yes 2 No Specify: Black Maryland 21215-0036 er than "natural", o , the Medical Exam If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry MD 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) State Correction Officer 12th N/A Correctional other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) : should be file n and Mental F is marked of ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. Gerald Brooks Sylvia Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Angela Brooks-Wife</u> 1504 Ralworth Rd Baltimore, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 9/24/2011 | Halethorpe, MD Arbutus Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H 1101 E. North Signature of Funeral Service Licensee Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ netastation disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or linjury that initiated events that the death certificate be executed sermon and trar resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year signed by the a d be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗌 No 1 Yes 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 NO ပ 1 Inpatient 2 FR/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred the Funeral Director: After appleted filled in by the funer injury 1 Natural 5 Pending work? 2 🗌 No Investigation Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one d. Date signed (Month, Day, Year) ture and title of certifie 29c. License number 29b. Sign 20d. Date signed process 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd Loch 5601 32. Registrar's State

DHMH 17 Rev 7/2009

Registrar

68760

Box

P.O.

Records,

Division of Vital

11-07006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Jay Bromwich State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle Last) Physician/ Month Day Y September 16, 2011 2235 hrs Medical Examine John Jay Bromwich 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's 10905 Indian Head Highway Fort Washington 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Foreign Missouri Min. Months Days Hours Director 489-76-1981 Oct. 8, 1963 47 1 X M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 Y No 28a-f show Lincoln Winfield Missouri permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a nr 28a-f she injury are rather tranmatic event, the Medical Examiner must be antified at nace s 23a nr 28a-f e nntified at n 10e. Street and Number 10g. Citizen of What Country 10f. Zip Code 565 Highway Y 63389 United States 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 Married 2 X No Yes White 1 Yes 2 X No specify: 3 Widowed 4 X Divorced f Yes, Give Year Specify. \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Construction 12 Floor Laver 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John Henry Bromwich Theresa Bertina Yelick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2261 East Highway 47, Winfield, MO Amanda Bromwich / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 09/24/2011 Winfield, Missouri Donation 5 Other Specify. Bethany Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Singleton Funeral & Cremation M01121 2nd Ave SW, Glen Burnie, MD 21061 Services, PA; Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line /Medical Death a. Contact Shotgun Wounds (2) of head and chest Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical tending physician are use as the burial -UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death 2 past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown q Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? signed by contributing to death but not resulting in the underlying cause given in Part I. ੬ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? page ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other; Nursing Home 5 Residence 6 ✔ Other: Scene DOA this No 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) Sep 16, 2011 After Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot himself twice Natural 2214 hrs 1 Yes 2 ✔ No neral Director: Pending death 2 Accident Investigation n 24 hours after d e Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Could not be Suicide or Town, State) 10905 Indian Head Highway, Fort Washington, MD

Registrar DHMH 17 Rev 1/2001 OCMF 2006

To the I within 2 Tn the I

Medical

State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

determined

30. Name and address of person who completed cause of death (Item 23a)

Homicide 29a. Certifier

29b. Signature and title of certifier

(Specify) Other (specify)

ar's Sig

and manner stated.

Assistant Medical Examiner

29d. Date signed (Month, Day, Year)

September 17, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G921 11/09/2011 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Dodian /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/ABaltimore ROLAND PARK PLACE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 Dec 28. 1920 Ohio 90 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 X Yes 2 □ No Maryland N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21211 830 West 40th Street, Apt 263 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married 1∐ Yes 2∭X No Baltimore, Maryland 21215-0036 Specify. Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Medical Illustrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pequignot Joseph Charles Widmont Nora r 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If item 27 is any Injury or other trau 803 Chumleigh Road, Baltimore, Maryland 21212 Brenda Jean Bodian (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Green Mount Crematory 9/20/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa /ofFuncial'S ce /ns e Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aortic STENUS 15 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division or Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ lymphoma 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed heart 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No 21 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 20 No 2 ER/Outpatient 3 DOA 1 Yes Certification: To 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2011 tem Name and address of person who completed cause of death (Item 23a) (Type, Print) Baitimore CHAYLES DON 5901 North any 32. Registrar's Signature 31. Date filed (Month, Day, State 2 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bryant 3100A obert September 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Center Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 219 30 6785 77 **Director** July 6, 1934 Kentucky "natural", or items 23a or 28a-f shov dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Windsor Mill Maryland 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Virunga Court 21244 USA death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc by 1 Never Married 2 Married Yes, Give 2 Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 Specify: White Korean 1 Yes 2 No Specify: 3 Widowed 4 M Divorced Completed Year or Dates. War ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Fabrication Elementary/Secondary (0-12) College (1-4 or 5+) Welder Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ည Herbert Andrew Bryant Cora Marie Harris item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 8723 Blairwood Rd. Nottingham, Maryland 21236 Charlotte Wagner (Partner) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o ■ Burial 2 □ Cremation 3 □ Removal from State 9/21/2011 Baltimore, Maryland Oak Lawn Cemetery 4 Donation 5 Other (Specify) up of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. <u> 1407 Old Eastern Avenue Essex, </u> MAryland 21221 23a/ Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Cancer Lun disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine tany, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of g physician and as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ detached for in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No Other: Nursing Home 5 - Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 Yes 2 No Accident filled in by the Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1514 apineM.D D0057465 Baltimore MD 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N - S RAMADA We M.D. 2835 Sm Th AV \$ 203 2835 Smith AV ·S. Kajapakse, M.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 0 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Maryland		artment o			d Mental Hy	giene Reg. No 20		29820
	Physici	an	1. Decedent's Name (First, Middle, La	,						2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Alice A. Bircl 4a. Facility Name (If not institution, gi		ber)		4b. City, Tov	vn, or Local	ion of De	Augus		y of Death	9:15 AM M
	LXuiiii		481 N. Patuxer		,			Odent			Anne	Arun	ndel
	Funeral Director		218-14-3545	Sex 7 1 □ M 2 🛛 F	. Age <i>(In yrs. la</i> 88	st birthday) Yrs.	If Under 1 Y Months D	ear If Ur ays Hou	nder 24 F urs N	lrs. 8. Date of Bir lin. July 29	th 1923	9. Birth Mai	place (State or Foreign ntry) 2 y Land
	the Maryland 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Anne 10e. Street and Number	Arundel		Town or Lo		nde			10g. Citizen of		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with		481 N. Patuxent	Rd.			10f. Zip Co 211	ĩ3			USA	What God	,.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is in affect levent must be realthed at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Forc 1 Tyes 2 If Yes, Give Year or Dat	es? No		Was Decedent If Yes, specify 1 ☐ Yes 2 🛣		c Origin? xican, Pu	(Specify Yes or No Jerto Rican, etc.)		ace - Ameri ack, White, ack, white,	
altimore, Maryland 21215-0036	vithin 72 hc ene. Ihan "natu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4		(Give life. I	dent's Usual O kind of work d DO NOT use n	ccupation lone during etired)	most of t	working	16b. Kind of E	Business/In	
1d 2	il Hygid other ent, II	e Co	17. Father's Name (First, Middle, Las		,	1105		18. N	fother's N	Name (First, Middle,			
ylan	Menta Menta arked atic ev	To Be	Clarence Irvin	g Arnold					F1or	a Paynter			
, Mar	and 2 sho saith and n 27 Is ma		19a. Informant's Name/Relationship Sheran Fraser		ughter	19b. Mailir 713	ng Address (Si	treet and N idge	umber or Poin	Rural Route Numb t; Homosa	er, City or Town SSA, FL	1, State, Zi 344	p Code) +6
imore	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Special	Removal from St		metery, crer	sition (Name on the state of the r place)		Date	20c. Location		own, State	
Balt	permit. Depart Import any inj		21. Sign fure of Inneral Service Licens (Specify) 21. Sign fure of Inneral Service Licens (Page 1) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201										21201
)	Physician /Medical Examiner	ler	23a. Part 1. Enter the disease, or consolon, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First the original cause, (Disease or injury)	a. Due to (or	r as a consequent	once of):	er the mode o	f dying, suc	h as care	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
38760,	ficate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	r as a conseque	ence of):							
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affer death. After the Funeral Director: After this certificate has been signed by the attending portion for the funeral Director. After this certificate has been signed by the funeral director, page 2 should be detached for use as tompletely filled in by the funeral director, page 2 should be detached for use as the complete of the property of t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 1 1 No 9 □ Unknown		th 2 ☐ Fetal on the state of the thick time of de	death 3 🖺	☐Ectopic preg ☐Other <i>(speci</i>				I	ate of deliv	very Day Year
	quires tha en signed uld be det		Part II. Other significant conditions	EICIEN		ting in the ur	nderlying caus	e given in F	art I.	23e. Did t		•	the cause of death?
Reco	he law requir e has been s ige 2 should I	Completed by	DIABETES M				-			24a. Was autor	osy ormed?	prior to co death?	opsy findings available ompletion of cause of
ta	iician: Thi certificate ector, pag	Be Co	25. Was case referred to medical	ZER-1	11/24	EVZE		26. F	Place of I	1 ☐ Yes Death (Check only o		1 □ Yes	2 No
of V	ding Physician: The lav. n. After this certificate has funeral director, page 2	2	examiner? 1 Yes 2 Yo		oatient 2 🗆 E	·			Nursin	g Home 5 ☐ Resi	dence 6 □ Ot	ther (Spec	ify)
ouo	ding Phys h. After this funeral di	ion:	27. Manner of Death 1		Injury Day, Year)	28b. Time of Injury	28c.	Injury at Work? 1 □ Yes	2 🗆 No	28d. Describe	how injury occu	rred	
Division of Vital Records,	I or Atten after deatl Director: I in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place o	f Injury - At hon , etc. <i>(Specify)</i>	ne, farm, str				28f. Location (ber or Rui	ral Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C			is of examinati					lace, and due to the occurred at the time,			
	To th withir To th comp	Me	29b. Signature and title of certifier				1	cense num	_	21	29d. Date sign	ed (Month	Day, Year)
			1			•		03	56	150	9/1	2	2011
			30. Name and address of person who DAVID GWIN F	-REAS	M.D.			ANDE	RMI	u BWD,	SUITE	250	MD 21054
	Sta Registr	te ar	SEP 2 0 201	1 Serve	gistrar's Signatu	far	de l'						

DHMH 17 Rev 1/2001

	92	ate
4	.89	artific
	Вох	death ,
	0.	at the
	ds, P	ires th
	ecor	par wel a
,	tal R	ian. Th
	of Vii	Physic
	Division of Vital Records, P.O. Box 6876	e Hospital or Attending Physician. The law requires that the death certificate
	Div	pital or
		e Hos

				Plea	se Type or I							•		gible.	
			For State Registrar		State of	Marylar		artment <i>tificat</i> e			and M	fental Hy	giene Reg. N.2 0		29821
Pl	nysicia Medic		1. Decedent's Name		^{Last)} Charles Ro	edd Be	easley					2. Date of De Month	eath Sep 8, 201	Year	3. Time of Death 2:45a _M
E	xamin		4a. Facility Name (If		give street and numb ella Maris	er)		4b. City, To	own, or	Location of Timon			4c. Coun	ty of Deat Bal 1	timore
Dir	ineral rector		5. Social Security No. 229-48-10 Usual Residence of	059	6. Sex 7	7. Age (In yrs. last birthday) 68 Yrs. If Under 1 Year If Under 24 Hrs Months Days Hours Min					24 Hrs. Min.	8. Date of Bir (Month, Da Jan			thplace (State or Foreign untry) VA.
faryland	8a-f shov tified at	ector	10a. State	10b. County Pete	rsburg City	10c. City, Town or Location Petersburg									10d. Inside City Limits 1 Yes 2 No
with the N	s 23a or 2 ust be no	Funeral Director	10e. Street and Num 2005 Colsto				10f. Zip Code 23803						10g. Citizen o	f What Co	
3036 urs after death	7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ted by Fun	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		12. Was Deceded Armed Force 1 Yes 2 If Yes, Give Year or Date	es? X No		Vas Deceder Yes, specify				cify Yes or No- Rican, etc.)	14. Ra Bl	rican Indian, ə, etc. ack	
21215-0036 within 72 hours after giene.	than "nat he Medica	Completed	Elementary/Seco	ndary (0-12)	's Education t grade completed) College (1-4	or 5+)	(Give k	ent's Usual (ind of work NOT use re	done d etired)		t of worki	ng	16b. Kind of	Business/	
land 2 be filed wi	ked other ic event, t	To Be (17. Father's Name (F		charlie I	Redd					er's Name		l Maiden Surnar ephine B e	,	
, Maryland d 2 should be filed auth and Mental Hy	r 27 is ma er traumat		19a. Informant's Na Josephine		p (Type, Print)							Route Numbe	er, City or Town,	State, Zip	Code)
Baltimore, permit. Page 1 and Department of Hea	ant: If iten ury or oth		20a. Method of Disp 1 ☐ Burial 2 ☐ 4 ☐ Donation	X Cremation	3 ☐ Removal from Specify)		Place of Disposemetery, crem Surry La		er place			Date 19, 2011	20c. Location		Town, State
Balt permit. Depart	Charlie Redo Josephine Phillips 19a. Informant's Name/Relationship (Type, Print) Josephine Phillips 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral S rvice Licensee						2 3 10	Name and 2 2 Sot	îdîk uth	ersc Ave	n F	unera] etersk	l Esta ourg,V	blis a. 2	shment,Inc. 3803
Physi			shock, or hear Immediate Cause (F disease or condition	f failure. List or Final	complications that cally one cause on each	line.		r the mode o	of dying						Approximate Interval Between Onset and Death
	edical miner	_	resulting in death) Sequentially list cor	nditions.		as a consequ									
executed	urial-transit	Examiner	if any, leading to im- cause. Enter or den Cause (Disease or in that initiated events resulting in death) L	mediate lying njury	с	as a consequ									
		edical	A STATE OF THE PARTY OF THE PAR	%.300	d										
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after this certificate has been signed by the changing physician the Emeral Director After this certificate has been signed by the changing physician	ched for use as the bu	~	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		nt 2 ☐ Fetant nt at time of c	ıl death 3 🗌	Ectopic pre Other (spec		/			- 1	ate of deli	ivery Day Year
IS, P.O.	pe d	[출	Part II. Other signif i	cant condition	s contributing to dea	th but not res	ulting in the ur	nderlying cau	use give	en in Part I		23e. Did to	11		the cause of death?
Division of Vital Records, tal or Attending Physician: The law requires is after death.		Completed										24a. Was autor perfo 1 \(\sum \) Yes	osy ormed?	prior to death?	opsy findings available completion of cause of
Vital	director		25. Was case referred examiner? 1 \sum Yes 2		Hospital:	natient 2 🗆	ER/Outpatient		Other	ce of Deat		only one)			fy) HOSPICE
sion of attending Photograph.	d in by the funeral o	Certificate: 1	27. Manner of Death 1 X Natural 2 Accident	5 Pending	28a. Date of (Month,		28b. Time of injury		. Injury work?	at	2		ow injury occur		W HOSFICE
Division Att	lled in by		3 ☐ Suicide 4 ☐ Homicide	6 Could n determir	28e. Place of	Injury - At ho , etc. <i>(Specify,</i>	me, farm, stre	et, factory, o	office		2	28f. Location (S City or Tow		ber or Run	al Route Number,
DIVI: To the Hospital or A within 24 hours after To the Euneral Direct	mpletely fil	Med	(Check 2 only one) 3	Medical Ex Certifying I	Physician: To the bes aminer: On the basis Jurse Practitioner: To	of examination	and/or investi-	gation, in my death occurr	opinior ed at th	n, death oc e time, dat	curred at	the time, date a	nd place, and d	ue to the c	ause(s) and manner stated.
5 wit	Ö		29b. Signature and ti	tile of certifier	CRNP			29c. L	icense 149	number 1792	2		29d. Date signe	201	, Day, Year)
ny			JACKIE	JONES,		O DULA	NEY VA	1	RD.	TIM	ONIU	M, MD 2	21093		
Re	State egistra	e r	SEP 2 (Day, Year) 2011	Server 32. Regi	istrar's Signa	are are								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 0

11 2982	2
---------	---

			ificate of Death	Reg. No.	
Physici Medical Exami		Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year September 12, 2011	3. Time of Death 0458 hrs
medical Exami	IIIGI	Clifford George Brissett 4a. Facility Name (if not institution give street and number)	4b. City, Town, or Location of Death		
		8628 Allenswood Road	Randallstown	Baltimore Co	unty
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las	Months Days Hours Min	T / / Tereio	gn .
		29 · 26 · 8594 1⊠ M 2□F Usual Residence of Decedent	†3 Yrs.	11/13/1937 00	ountry) MD
w any			own or Location		10d. Inside City Limits
Aaryland 28a-f show	to	MD Balfimore	Randallstown	100 Citizen of What Cou	1 Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland calth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Funeral Director	8628 Allanswood Road	21133	10g. Citizen of What Cou	nuy?
eath wir	nera	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No	. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	ican Indian, Black,
after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify:	Hack
hours natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of viduring most of working life, DO NOT use reting the control of the control		
D36 thin 72 ne.	Completed	(Oth grade) N/A	Custodian	Compar	
MD 21215-0036 d 2 should be filed within 72 hours a th and Mental Hygiene. n 27 is marked other than "natural numatic event, the Medical Examin	e Cor	17. Father's Name (Pirst, Middle, Last) George C. Brissett		(First, Middle, Maiden Surname)	
2121 Muld be fil Mental I marked	To Be	19a Informant' Lame/Relationship (Type Print)	19b. Mailing Address (Street and Number or F	Rural Route Number, City or Town, State	
and 2 should and 21 fealth and Me item 27 is ma traumatic ev		Cathern Brissett /Wife	8628 Altenswood Ro		
Fright Fig.		1 Burial 2 Cremation 3 Removal from State Cr	ace of Disposition (Name of cemetery, ematory or other place)	Date 20c. Location - City or	·
토 스 의 를 된다		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		17/201 Baltimor	
Balti permit. Departm Imports injury o		Vaugh C. es	8728 Liberty Road	a Randallstown Mi	21133
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause Final disease or condition resulting in death) Lymphoma Due to (or as a consequence of):			Deau
		Sequentially list conditions, b.			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disusse or injury that initiated			
ited J ansit		events resulting in death) Last Due to (or as a consequence of): d.			
68760, certificate be executed nding physician and ise as the burial - transit	Medical	UNPENDED AMENDED			
760, ficate be g physici the buri		IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth		23d. Date of deliver	
Box 687 c death certifice the attending p ed for use as th	Physician/	past 12 months? 4 Pregnant at time of deal	2 Fetal death 3 Ectopic pregna h 5 Other (Specify)	incy Month I	Day Year
D.O. BO) that the death ned by the att detached for	Phys	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
8 <u>30</u> 9	ā	Tark Card Significant Conditions Contributing to death but not res	uiting in the underlying bause given in rait i.	1 Yes 2 No 3 ✔ Prot	
cords, P law requires that be seen signs 2 should be de	Completed				topsy findings available completion of cause of
Reco The law cate has	mo.			performed? death? 1 Yes 2 ✓ No 1 Yes	
tal Recieism: The certificate ector, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check of R/Outpatient 3 DOA Other Nursin		
ion of Vital Rec tending Physicias: The I eath. for: After this certificate I the funeral director, page	유	1 ✓ Yes 2 No	R/Outpatient 3 DOA Outlet Nursin 28b. Time of Injury 28c. Injury at Work?	g Home 5 Residence 6 ✔ Other 28d. Describe how injury occurred	r: Scene
ion tendin eath.	ation	1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No		
Division of Vital Records, rate or Attending Physician: The law requir rs after death. *I Director: After this certificate has been sited in by the fineral director, page 2 should the fineral director, page 2 should the fineral director.	Certification:	3 Suicide 6 Could not be	ne, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State)	ral Route Number, City
Hospita 4 hours Funera		4 Homicide 29a. Certifier	e death occurred at the time, date and place, and	due to the cause(s) and manner as state	ed
Division To the Hospital or Attendi within 24 hours after death, To the Funeral Director:	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.		t the time, date and place, and due to the	e cause(s)
	ž	29b Signature and title of certifier	29c. License number	29d. Date signed (Mo.	
		30. Name and address of person who completed cause of death (Item 2	O.C.M.E.	September 16, 2	VII
51			ner 900 W. Baltimore Street, Baltim	nore, MD 21223	
St	ate	31. Date filed (Month, Day, Year) 32. Flegistrar's Signature	back		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 29823 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Burley Sentenber 10 AMES 1:13 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE BURNIE Naton Medical Center If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Months Month Day Year) Jul 16, 1933 Days Min. 219-30-2462 78 Yrs **Director** Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits

X
1 □ Yes 2 □ No 10c. City, Town or Location notified at Director **Pasadena** 28a-f Anne Arundel 10e Street and Number ms 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 U.S.A. 8178 Hog Nick Road items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ortant; If item 27 is marked other than "natural", or ite injury or other traumatic event, the Medical Examiner was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No**5/24/1955** Black, White, etc. þ 1 Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. **Black** If Yes, Give Year or Dates 6/22/1055 Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Surkey, James Elementary/Seconday (0-12) College (1-4 or 5+) **Private Bus Service** Driver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked or Department of Health and Menta Important. If item 27 is marked , any injury or other traumations. ည Ruth Burley James A. Burley Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8178 Hog Neck Road Pasadena, MD 21122 June Burley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sep 16, 2011 Crownsville, Md. **Crownsville Veterans Cemetery** 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ MOMONIA disease or condition resulting in death) Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Due to (or as a consequence of): -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Funeral Director: After this certificate has appleted filled in by the funeral director, page 2.3 autopsy performed? Yes 2 No 2 🗌 No Yes 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 ► Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending death. Investigation М Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Pr only one) 29b. Signature and tal 1002248 eted cause of death (Item 23a) (Type, Print

State

JACOBS

Mb

32. Registrar's Signatur

Nespital Dr. Clan Burnic, mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bu11 Jr. Merle Edward 2011 Sept Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 212-22-0753 1**X** M 2 □ F Dec.12,1925 Maryland Maryland 85 Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at **Funeral Director** 1 ☐ Yes 2X No MD Baltimore Lansdowne ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a IISA 21227 200 First Avenue items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2XXMarried "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Personal Supervisor 3+Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Maxine Ridenour Edward Merle Bull Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important. If item 27 is any injury or other trauonce. Elizabeth Bull-Wife 200 First Avenue Lansdowne Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Crownsville Vet Cem Sept. 16,2011 Crownsville MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ NUTES disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on. burial-transi Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the at id be detached fo Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? certificate 2 No 2 1 No Yes director, To Be 25. Was case referred to Medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 f after death.

Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours and To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item

2011

20

Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

even Austir	n Bra	1- For State Registrar Certificate		Hygiene 2011	29825
Phys edical Exa				2. Date of Death Month Day Year September 17, 2011	3. Time of Death 1240 hrs
		4a. Fecility Name (if not institution, give street and number) 706 Lake Drive	4b. City, Town, or Location of Dea Westminster	th 4c. County of Death	1
Funer Direct) If Under 1 Year If Under 24H Months Days Hours Mi	1 Foreign	
nd show any	70 000	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Carroll Westmi			10d. Inside City Limits 1 Yes 2 X No
he Maryla or 28a-f	e notified at once.	10e. Street and Number 706 Lake Drive	10f. Zip Code 21158	10g. Citizen of What Cou	ntry?
r death v	must b	11. Marital Status 1 \(\sum \) Never Married 2 \(\sum \) Married Armed Forces? 1 \(\sum \) Yes 2 \(\sum \) No 3 \(\sum \) Wildowsd 4 \(\sum \) Diversed IV Yes Give Year.	Was Decedent of Hispanic Origin? (§ If Yes, specify Cuban, Mexican, Puert Yes 2 No specify:	Specify Yes or No- 14. Race - Amer	ican Indian, Black,
5-0036 led within 72 hours a Hygiene.	Cal Exam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) St	dent's Usual Occupation (Give kind of g most of working life. DO NOT use re udent	school	Industry
MD 21215-003 2 should be filed within h and Mental Hygiene. 27 is marked other tha	event, the	Thomas Benjamin Brannock, Jr.	Tracey	ne (First, Middle, Maiden Surname) Lynn Leppo Rural Route Number, City or Town, State	7-0-10
e, MD 2 l and 2 shou Health and N	aumatic ev	Carolyn Brannock - gr.mother 7	06 Lake Dr. We	stminster, MD. 2	21158
Baltimore, M permit. Pages 1 and 2 Department of Health Important: Vitem 2	or other tr	1 Burial 2 Cremation 3 Removal from State crematory of 4 Donation 5 Other Specify: All Fa	iths Crematory	Date 20c. Location - City or 2011 Manchest	er, MD.
Balt permit Depart Impor	injury			ckhardt Funeral . Manchester, MI	
Physicia /Medic ====================================	al	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a. Hanging			Approximate Interval Between Onset and Death
S.A.		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
p.	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
60, tte be executed hysician and	unal - tran	d AMENDED	.		
lox 6876 leath certificat attending phy	စ္က 🤰	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn	23d. Date of deliven	/ Day Year
s, P.O. ires that the signed by t	≦ ge		e underlying cause given in Part I.	23e. Did tobacco use contribute to 1 Yes 2 No 3 Prot	
	Comi	25. Was case referred to medical	26.Place of Death (Check	autopsy prior to death? 1 ✓ Yes 2 No 1 ✓ Yes	topsy findings available completion of cause of
Vital hysician	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other	ng Home 5 Residence 6 🗸 Other	: Scene
sion of Vital ttending Physician: death.	y the tuneral	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: Day, Year) FOUND: Sep 17, 2011 1224 hrs	1 Yes 2 ✔ No	28d. Describe how injury occurred Subject hanged self	
Div	y filled in by the tune Certification:	3 Suicide 6 Could not be 4 Homicide determined (Specify) Single Family Home		28f, Location (Street and Number or Ru or Town, State) 706 Lake Drive, Westminster, MD	
To the Hospital within 24 hours To the Funeral	com letely	(Check only one) 1 Certifying Physician: To the best of my knowledge, death ocone) 2 Medical Examiner: On the basis of examination and/or investiged and manner stated.		• • •	
	Š	29b. Signature and title of certifier (We of Hullan)	29c. License number O.C.M.E.	29d. Date signed (Mo) September 18, 2	
1		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. B	altimore Street, Baltimore, N	ID 21223	
	State istra	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

29826 State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ sept. 20ÎÎ 4:45a M Spencer Pierce Bauerlien Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Carroll Hospice Dove House Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min A (Month, Day, Zear) 1925 cmaryland 1 ₹ M 2 □ F 218-26-1600 86 Yrs Director Usual Residence of Decedent 28a-f show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Directo Maryland 1 Yes 2X No Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1211 North Main St. Apt. 21074 U.S.A. 202 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2 X No Specify: Specify: 3X Widowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Cabinet Maker Lumber Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Edward Henry Bauerlien Florence Elizabeth Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Nina Brafford - daughter 3406 Lineboro Rd. Manchester, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20° te 2011 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State Evergreen Mem. 4 Donation 5 Other (Specify) Gardens Finksburg, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel Harth 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed for use as the burial-transi the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Day 1 Yes 2 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NOther (Spec this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \sum Yes 27. Manner of Deat 28b. Time of s after death. Certificate: 28d. Describe how injury 1 Natural injury 5 Pending 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

104

21215-0036

Marviand

Baltimore,

Box 68760

Division of Vital

State

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

SEP 20

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 224 Washington Heights Medical Center

29d. Date signed (Month, Day, Year)

Please Type or Print in Blace	ck Indelible Ink. Ensure All Copi	ies Are Legible
State of Maryland / I	Department of Health and Mental H	-lygiene

			For State		State of M	larylan		artment of F		and M	lental Hy	giene	וחכ	1	29827
			Registrar 1. Decedent's Name (Fig. 1)	irst Middle I as	<i>t</i>)		Cer	tificate of L	<i>Jeatn</i>		2. Date of De	Reg. N6	<u> </u>	1	3. Time of Death
	Physicia Medic		T. Boodanie Wano (Merri	,	С.	В	lalock			Sept.	1 ^{Da}	y 2	Year 011	4:15 A M
i dang	Examir	_	4a. Facility Name (if not		· ·			4b. City, Town, or				4c.	. County o		
	<u> </u>		Stella Ma 5. Social Security Numb		spice Cen		st birthday)	Tir	noniun		8. Date of Birl		Ва	alti	more
^	Funeral Director		_ 212-32-578		M 2 🗆 F	78	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	,,	Count	try)
	o w	L	Usual Residence of D				, Town or Lo	etion			June 1	0,19	33		th Carolina Od. Inside City Limits
	arylanda-f sh	cto	MD	,	ltimore	Tue. City	, Iown or Loc		D . 1-	11_					1 ☐ Yes 2X No
	or 28 e noti	Dire	10e. Street and Numbe					10f. Zip Code	Dunda	IIK_		10g. Cit	tizen of WI	hat Coun	try?
	s 23a	Funeral Director	1204 Key	ywood Co	ourt			2122	22			Un	ited	Sta	tes
036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show tedical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4 ☐		12. Was Decedent Armed Forces? 1 XYes 2 If Yes, Give Year or Dates.		l1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛣 No	n, Mexican,	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		14. Race Black Specify:	- America , White, e	etc.
5-0	2 hour "natu	plet		5. Decedent's Ed only highest gra			16a. Deced	ent's Usual Occup	ation during most	of workii	na	16b. K	ind of Bus	siness/Ind	dustry
121	ithin 7 ene. • than he Me	Completed	Elementary/Seconda		College (1-4 or	5+)	life. Do	NOT use retired) lworker	Ŭ			s	teel	Ind	ustry
10 2	iled w I Hygi other vent, t	Be	12 Years 17. Father's Name (First				Stee	IWOIKEI	18. Mothe	er's Name	(First, Middle,				
ylar	should be filed within 72 n and Mental Hygiene. 7 is marked other than "r raumatic event, the Med	욘	Balfour	r Cowan	Blalock				Pe	earl	Colson				
, Maryland 21215-0036	1 and 2 should be filed within 72 hour f Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical		19a. Informant's Name Lisa M. St			ghter		g Address (Street a		r or Rura 1 th	Route Numbe Surfsi	r, City or de B	Town, Sta Beach	ste, Zip C SC	29575
Baltimore,	permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau		20a. Method of Disposi 1 ☐ Burial 2X 0 Donation 5	Cremation 3	Removal from State		emetery cren	sition (Name of natory or other place Service (Corp.		oate 7/2011		ocation - 0		wn, State ryland
Balt	permit Depart Impor any in		21. Si val ve of Funera	al Service Licens		20		Name and Addres uda – Ruck 7922 Wise	Funei Funei Ave.	ral l Dun	Home of	Dun MD	da1k 2122	In	с.
	Physician		23a. Part 1. Enter the of shock, or heart fa Immediate Cause (Final disease or condition	ilure. List only o	olications that cause ne cause on each lir	e.		r the mode of dyin	g, such as c	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death
4	Medical Examiner		resulting in death)	•	Due to (or as										
		iner	Sequentially list condit	tions,	b. Eus to (or ex	a consicu	enne oty								
	and transit	xam	Cause (Disease or injust that initiated events resulting in death) Last	ry	c Due to (or as	2.00000011	anco of:								
0	cate be executed physician and the burial-transit	edical Examiner	resulting in death) Last	Ĺ	d d	a consequ	ence on.								,
68760	ificate ig phy as the		IE EELAN E		u					-					
Вох	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to the Funeral Director, page 2 should be detached for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	nths?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Fetal	l death 3 🗌	Ectopic pregnand Other (specify)	у				23d. Date Mont		ery Day Year
, P.O.	ss that tigned by	by P	Part II. Other significal	nt conditions co	ontributing to death	but not resu	ulting in the u	nderlying cause giv	en in Part I.						e cause of death?
rds	require	eted									1 🗆	/			oably 4 Unknown
Records,	2 SS S	Compl									24a. Was autoj perfo 1 🗆 Yes	psy ormed?	pr de		mpletion of cause of
ital	sician: certific rector,	Be	25. Was case referred to examiner?		Hospital:			Othe	ace of Deatl					-	
of V	Phys r this eral di	e: To	1 ☐ Yes 2 👿 N 27. Manner of Death	10	28a. Date of ini	ury	ER/Outpatien 28b. Time of	t 3 □ DOA 28c. Injury	4 ⊔ Nui ⁄at		ne 5 Resid				HOSPICE
ou	anding ath. rr. Afte he fun	icat	2 Accident	Pending Investigation		iy, Year)	injury	work	? Yes 2 🗆						
Division of Vital	Hospital or Attend 24 hours after death Funeral Director. A etely filled in by the f	Il Certii	3 ☐ Suicide 6 4 ☐ Homicide	determined	28e. Place of In	ury - At hor c. (Specify)	me, farm, stre	et, factory, office		2	28f. Location (S City or Tow			or Rural	Route Number,
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Certificate:	(Check 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Medical Exami Certifying Num	sician: To the best oner: On the basis of the Fractitioner: To the	examination	and/or invest	igation, in my opinio	n, death oc	curred at	the time, date a	and place	, and due t	to the cau	use(s) and manner stated.
	To the within To the comple		29b. Signature and title	of certifier	OCAN	P		29c. License	number 149	79	2	29d. Da	te signed	(Mgnth, l	Day, Year)
X	Í		30. Name and andress JACKIE JO	ONES, CI	completed cause of ca			rint) LLEY RD.	TIMO	ONIUN	1, MD 2	/ 1093	1		
	Stat Registra	_	31. Date filed (Month, 9)	P 2 0 20		ar's Signati	ure	100							
/				· ~ U CU	City	1 /c	7. X 4								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 18 2011 **Physician** Margaret Wedron Bridwell 6:30 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Brighton Gardens 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Sept. 5, 5. Social Security Number . 19<u>23</u> **Funeral** Days Hours Min Country) Kansas 438-28-3618 1 □ M 2 🗓 F **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Columbia 4 8 1 Maryland Director Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21044 10996 Swansfield Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 X Widowed 4 □ Divorced "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Medica1 Doctor permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If Item 27 is marked other the amy injury or other traumatic event, II agnes. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Peggy William S. Wedron ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3622 Hawk Ridge Street, Round Rock, TX 78665 L. Clayton Bridwell - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory, Inc. 09/20/11 Glen Burnie, MD 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Road, Columbia, MD 21045 MO1283 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tra Due to (or as a consequence of) Physician/Medical attending properties of the second 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the To the I within 2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

101 State Registrar

Medical

(Check only one)

29b. Signature and title

Andrew

31. Date filed

certifie

Laris

30. Name and address of arson who completed cause of death (Item 23a) (Type, Print) #103, Columbia, Maryland 21044 Andrew Laris, M.D. 6334 Cedar Lane

29c. License number

D47447

29d. Date signed (Month, Day, Year)

09/19/2011

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieng Certificate of Death Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 18:26 SEPTEMBER 12 2011 CARRINGTON VIYIAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE JOHNS HOPKING BAYVIEW MEDICAL CENTER Yea*r*) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖫 F 25 08 VΔ 228-28-9081 86 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ∐Yes 2X No Dundalk Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 U.S.A. Completed by Funeral 201 Walnut Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify. Specify: Black 3 ₩ Widowed 4 Divorced 'natural", 16b. Kind of Business/Industry Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Distribution Postal Elementary/Secondary (0-12) College (1-4or 5+) the Consultants Inserter Operator 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental is marked Maggie Jones Lewis Johnson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important; If Item 27 is any injury or other trauonce. Lewes, DE 19958 17790 Seashore Drive, LaVerne McIntyre-Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mills, Md 9/21/2011 Owings Garrison Forest 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee Part 1 Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, md 21215 Approximate Interval Between Onset and Death Imme late Cause (Final disease or condition resulting in death) **Physician** ANOXIC GNOEPHALOPATHY rag 1 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manyer of Death After the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident hin 24 hours after death the Funeral Director; filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ٥ SEPTEMBER 12, 2011 RE5-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 BASTERN AVENUE, BALTIMORE, MD. 21224 WOLLE 32. Registrar's Scinature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** exa n a /Medical 4c. County of Death acility Name (If not institution, give street and number) **Examiner** all If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 1 M 2 □ F 80 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Executary must be notified at 1 Nes 2 No timore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 201 oswe Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♠ No permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items; any injury or other traumatic event. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retified) ary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17, Father's Name (First, Middle, Last) Be ena City or Town, State, Zip Code) Relationship (Type. Print) 19b. Mailing Address (Street and Number of Place of Disposition (Name of Cemetery, crematory of other 20a. Method of Disposition Woodlaws 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee Approximate Interval Between Oncet and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or head ailure. List only one cause on sach line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown is been signed by the 9 Unknown Part II. Other etanificant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform 2 No 2 No 1 ☐ Yes certificate 1 Tyes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 hor To the Fune completely fi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 101 Kors Rid (01

Registrar

State

Registrar's Signature

			Plea	se Type o								•		_	ible.		
	1	For State Registrar		State	of M	larylan		artmen rtificate			and M	lental Hy	gien Reg. N	~ ~		29831	
Physician/ Medical	. Decedent's Nam	Last)	Mar	ie			orcora			2. Date of Death Month 18			2011 2011	3. Time of Death 09:35 a M			
Examiner	4	a. Facility Name (ii						1	4b. City, Town, or Location of Death Lutherville—Timonium					4c. County of Death Baltimore			
Funeral Director	5	Stella Mar Social Security N 219-38-658	DE 6. Sex 1 □ M 2 X F	7. Ag	ge (In yrs. la	ast birthday) Yrs.	If Under Months		If Under Hours		8. Date of Bir (Month, Da 08/28/19	irth 9 Birthplace (place (State or Foreign htry)			
nd how at		Usual Residence 0a. State					, Town or L	ocation				00/20/13	/ 		1	10d. Inside City Limits	
Marylar 28a-f s otified		MD	Balti	nore		Ba	ltimore	9								1 🗆 Yes 2 🕅 No	
leath with the Marylanc tems 23a or 28a-f she er must be notified at Funeral Director	1	0e. Street and Nu		le.				10f. Zip				ļ	10g. 0 J . S.	Citizen of V A.	What Cou	ntry?	
° L.9		1. Marital Status 1 Never Marital Status 3 Widowed	ried 2 🔀 Marri	12. Was Dec	orces? 2 X ive		3. 13.	Was Deced If Yes, spec				cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			etc.	
21215-003 ifthin 72 hours af leine. r than "natural" the Medical Exe		(Spe	15. Deceden ecify only highes	t's Education at grade complete	d)		(Give	edent's Usua kind of wor	k done d		st of worki	ing	16b.	Kind of Bu	usiness/Ir		
within giene.		Elementary/Sec 12	ondary (0-12)	College	1-4 o <u>r</u>	5+)		tant Pr	- '	al			Ed	ucatio	n		
Maryland 21215-0036 2 should be filed within 72 hours after tith and Mental Hygiens 27 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by	1	7. Father's Name Benjamin	7. Father's Name (First, Middle, Last) Benjamin					Raybold 18. Mother's Name (First, Middle Rosemary						n Sumame nn		allahan	
Mar 12 shou lith and 27 is m	ľ	19a. Informant's N Michael F		p (Type, Print) n, Jr., Hu	shan	nd	1	-				nore, MD			State, Zip	Code)	
altimore, mit. Page 1 and partment of Hea portant: If item y injury or other ce.	2	0a. Method of Dis	position	3 Removal fro		20b. P	lace of Disp emetery, cre	osition (Nan	ne of ther place	e)	[Date	20c.	Location -	•	own, State	
altim mit. Pag partmen sortant: 'injury	2		5 Other (Spineral Service Li			Hil					09/20 _{ity}	/2011 .eonard J		vson, ck, Ir		and	
Ball permit Depar Impor any in	1	Hilltop Svc. Corporation 09/20/2011 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate															
∠ Physician/			art failure. List or (Final	nly one cause on e	each lin	e.				g, such as	cardiac c	or respiratory ar	rest,		Į.	Approximate Interval Between Onset and Death	
Medical Examiner		resulting in death)				a consequ	GASTR I lence of):	C CAL	CER						\neg		
xecuted and al-transit	E	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate	b. Due to	o (or as	a consequ	ience of):										
= 12. ag e		that initiated even resulting in death)			o (or as	a consequ	uence of):			-							
68760 certificate be nding physic use as the b	-	F FEMALE:		d				-									
Box death of the atterned for u	2	3b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	months?		e Birth gnant	e of pregna 2 Feta at time of c	death 3	☐ Ectopic p☐ Other (sp		y	, ,				te of deliventh	rery Day Year	
ords, P.O. v requires that the the been signed by the should be detacl		art II. Other signi	ficant condition	ns contributing to	death	but not res	ulting in the	underlying	cause giv	en in Part	i.	23e. Did t		use control		he cause of death?	
Records, P. The law requires the case has been signed, page 2 should be d	. .											24a. Was auto perfo 1 \(\sum \text{Yes}\)	psy		prior to co death?	opsy findings available ompletion of cause of	
/ital sician: certific irector,	2	25. Was case reference examiner?	red to medical	Hospital:	٦				Othe	ace of Dea		only one)	- 7.			HOCDICE	
Division of Vital Recontrol the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certificate: To Be Comp	2	7. Manner of Dear		28a. Dat (Mc	e of inj		ER/Outpation 28b. Time of injury		8c. Injury work	/ at		28d. Describe				HOSPICE	
Division of he Hospital or Attending P in 24 hours after death. he Funeral Director: After t pletely filled in by the funera Medical Certificate:		3 ☐ Suicide 4 ☐ Homicide	6 Could r determi	28e. Plac	e of Inj ding, et	jury - At ho c. (Specify	me, farm, st	reet, factory	, office			28f. Location (City or Tou			er or Rura	Il Route Number,	
Divisio To the Hospital or Attenwithin 24 hours after deat for the Funeral Director: completely filled in by the Medical Certific		(Check :	2 Medical E	Physician: To the caminer: On the b Nurse Practition	asis of	examination	and/or inve	stigation, in	my opinio	on, death o	occurred at	the time, date	and plac	ce, and du	e to the ca	ause(s) and manner stated.	
To t	2	29b. Signature ap	title of gertifier	SCRN	P			290	RIG RIG	number	92		29d. C	ate signe	Wonth,	Day, Year)	
	3	JACKIE	ress of person v				23a) (Type, NEY V		RD.	TIM	ONIU	M, MD 2	109	3			
State Registrar	3	1. Date filed (Mon		32.	_	er's Signat	ture	back									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 17, 2011 3:43 John F. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 22 **Funeral** 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Days Min. Year) 948 Utah 63 Director 529-68-1816 Usual Residence of Decedent 10a. State with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. inside City Limits Director Maryland Montgomery Bethesda 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8316 Comanche Court 20817 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? "natural", or iten edical Examiner r Black, White, etc 1 Never Married 2 K Married þ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 😾 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Attorney Ith and Mental Hygie 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John F. Clark Margaret Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Carole Ann Clark / Wife 8316 Comanche Court, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 X Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1, 2011 Salt Lake City, Utah Signature of Funeral Service Ligensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 letteBana M01305 Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Immediate Cause (Final as desiosalesotic cochovaxules dis Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical use as the Division of Vital Records, P.O. Box 6876 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 1 L Yes 2 L g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural
2 Accider 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1___Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

— Curtifying Nurse Practice of To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and in more as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 55410 Hergemy Guchelman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

SFP 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 905 PM Physician/ Margaret Marie Coulson Septen Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Harford Bel Air Upper Chesapeake Med. Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day Year) av 23, 1931 Maryland Hours 1 🗆 M 2 🗶 F 215-28-5584 80 May Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 XYes 2 ☐ No Forest Hill Harford |Marylan¢ 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UŠA 21050 Funeral 1 Colgate Drive death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. "natural", or iten edical Examiner n 11 Marital Status Armed Forces?
1 ☐ Yes 2X No
If Yes, Give Black, White, etc. Specify: White <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Civil Service Elementary/Seconday (0-12) College (1-4 or 5+) Administrator 0 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic evence. Sallie Crabbe Deward Hackler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1237 Rigby Hall Court, Belcamp, MD Savannah McGee / Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/21/2011 Bel Air Air Mem Gdns. 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P
333 S. Parke St, Aberdeen, MD 21. Signature of 5 meral ervice 1001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between RIE Immediate Cause (Final Physician/ hours disease or condition T Medical resulting in death) Due to (or as a onsequence of) Examiner 4090 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): W Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran MAKCAR Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has I autonsy death? 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည After this 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 28a. Date of injury 27. Manner of Death Certificate: (Month, Day, Year) injury 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 To the I 29d. Date signed (Month, Day, Year) D0053568 September 17 esapea of pason who completed cause of death (Item 23a) (Type, Print) MD non State Registrar DHMH 17 Rev 7/2009

ORIGINAL

11-06911		Please Ty	ре о	r Print i	n Bla	ck Ind	elible li	nk. En	sure	All Cop	ies Are l	_egib	le.		
evy Ferrer Calz	ado		state	of Maryla	and / I	•			and	Mental	Hygiene		20		2983
		1- For State Registrar				Certif	ficate of	Death				Reg. N		3 1	
Physicia Medical Exami			RER	CA		DO, 3					2. Date of I Month Septem	Da 1ber 13			3. Time of Death 1250 hrs
, in the second		4a. Facility Name (if not institu 9501 Ridgely Avenu		e street and no	umber)			4b. City, Too Parkvill		ocation of De	ath		4c. County of Baltimor		
Funeral		5. Social Security Number	6. Se	×	7. Age (In yrs. last	birthday)	If Under		If Under 24				9. Birt Foreig	thplace (State or
Director		229-47-7373	1 <u>X</u>	M 2 F		37	Yrs	Months	Days	Hours M	^{viin.} 08/0	7/1	974		untry) MD
any		Usual Residence of Decedent 10a. State 10b. Coun	,		110	Oc City To	wn or Locat	on							10d. Inside City Limit
				MORE		•									1 Yes 2 XN
nylano	Director	10e. Street and Number	ГТТ	MORE		<u>.</u>	PARKV	1 L L E 10f. Zip C	ode			10g. C	Citizen of Wh	at Cour	
the Mar or 2	Dire	9501 RIDGE	LY	AVENU	E				212:	3 /			U.S	. A.	
with ms 23.	Fra	11. Marital Status		12. Was Dec	cedent Ev	ver in U.S.	13. Wa	s Decedent	of Hispa	anic Origin? (Specify Yes or	No-			can Indian, Black,
death or ite	Funeral	1 Never Married 2		1 Yes	2 🔀	No No					erto Rican, etc.)		White		
s after ral",	ρ	Widowed 4 15. Decedent's Education (S		If Yes, Give Yes or Dates:		-115 46		Yes 2				Lea	Specify:		VHITE
2 hour	ted	Elementary/Secondary (0-1)		College (during m	ost of workir	cupetiong life. [on (Give kind DO NOT use i	ot work done retired)	160	o. Kind of Bu	siness/ii	naustry
D36 thin 7 ne.	Completed	12					MERC	HANT	MAI	RINE			SHI	PPI	ING
215-0036 be filed within 7 ntal Hygiene rked other than		17. Father's Name (First, Midd							18	3.Mother's Na	me (First, Midd	le, Maide			
	o Be	LEVY FERR	77	CAL	ZADC	, SR				ANN			IHLE		
MD 21 d 2 should ith and Me a 27 is ma numatic ev	۲	19a. Informant's Name/Relatio									or Rural Route I				
and 2 and 2 lealth traup		20a. Method of Disposition	/ 111	OIRER		20b. Plac	9501 ce of Dispos	RIDC tion (Name	of ceme	(AVE) etery,	NUE PA	RKV 20	C. Location -	MD City or	21234 Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremati	_	Removal fr	rom State		natory or oth		7 m.c		110111				
Baltin permit. P. Departme Importan injury or		4 Donation 5 Other 21. Signature of Fraeral Service		see /		DAI	22. N	ame and Ac	dress o	ORY 19/	/19/11	B	ALTIM	ORE	, MARYLA
	-	forday (3)	X	Ener.			- 1	ւ ቅ ይ	EAS	STERN	ER INC AVENU	Ē.B	UNERA ALTO	LH	OME 21231
Physician		23a. Part I. Enter the disease, failure. List only one caus			aused the	e death. Do	not enter th	e mode of o	dying, su	uch as cardia	c or respiratory	arrest, s	shock, or hea	irt	Approximate Interval Between Onset and
/// /Medical Examiner		Immediate Cause (Final disease	e a	Diabet			idosis	3							Death
		or condition resulting in death)	b.	Due to (or as a	consequ	uence of):									
	Jer	Sequentially list conditions, if any, leading to immediate		Due to (or as a	consequ	uence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Las	C.	Due to (or as a	consequ	ience of):									/
ecuted and - transit	a Ex	events resulting in death) Las	d												
be exec brician a	dica	⅓ UNPENDED		AMENDED	23a,	pt.II	,27,p	er me,	g91	9 9-27	-11 sm				
Box 68760, e death certificate be ex the attending physician ed for use as the burial	N N	IF FEMALE: 23b. Was decedent pregnant in	the	23c. If yes,		of pregnan	_	al doath	3	Ectopic preg	anancy.	2	23d. Date of Month		ay Year
x 68 h certi tendin	iciai	past 12 months?				ne of death	- =	al death ner <i>(Specify</i>		Teropic bieg	grianicy	Į.	MOUTH		real
Bone deat	Physician/Medic	1 Yes 2 No 9 U		9 Unkno											
Division of Vital Records, P.O. B. tal or Attending Physician: The law requires that the de rs after death. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached for		Part ii. Other significant cond Atherosclero		Contributing to				, ,	iuse giv	en in Part I.				_	the cause of death? ably 4 Unknown
ds, equires	Completed by	Acherosciero	LIU	Caruio	vasci	штаг	DISEA				24a. W				topsy findings available
COL	ğ										pe	itopsy erformed	? d		ompletion of cause of
Reifficate	ខិ	25. Was case referred to media	at I					26	Place o	f Death (Ched		s 2	No 1	✓ Ye	s 2 No
/ital	å	examiner? 1 ✓ Yes 2 No	_	ospital:	Inpatient	2 ER	/Outpatient			ther =	sing Home 5	Resi	dence 6	Other	: Scene
ing Phy	٩	27. Manner of Death		28a, Date (Month	of Injury	28	b. Time of Ir	njury 280	; Injury	at Work?	28d. Descril		njury occurre		-
ion ttendi: leath. tor: /	atio		nding estigatio	1	,, , , , , , ,	'		1	Ye	s 2 No					
Division of Vipital or Attending Phons after death. Reral Director: After t	Certification	3 Suicide 6 Co	ıld not b	28e. Plac	e of Injury	y - At home	, farm, stree	t, factory, of	fice bui	lding, etc.		n (Stree		r or Rur	ral Route Number, City
ospital hours uneral y filler	ខ្ញុ	4 Homicide	ermined	(Opcony)											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the bunial	Medical	(Check only one) 2 Medical Ex	aminer.		of examin						nd due to the ca d at the time, da				
HSHS	ž	29b. Signature and title of certi)			29c, L	icense r	number		290	d. Date signe	d (Mon	ith, Day, Year)
		You Uro	N.C	w-to	oll.	ch N	Ю		D.C.M.	.E.		Se	eptember	14, 20	011
7		30. Name and address of person Patricia Aronica-Poll				,	,	200.10/ 12	altim-	ara Ctrast	Raltima	MD 2	1222		
		atriola Atoliica-Poli	W IAID	Assista	ALL MICO	JICAI CX	arrinter :	OU VV. B	ailiiii	Jie Street,	Baltimore,	IVID Z	1223		

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 29835 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 3-34 AM Sep Barbara Ann Curley Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Hospital St. Agnes Balti more If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X Months Davs Hours N. Carolina b3 9 6 4 7 1 9 4 0 220-36-2842 71 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other than "----10b. County 10a. State 10c. City. Town or Location Director 1 X Yes 2 No N/A Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral U.S.A. 21215 4021 Rosecrest Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 😾 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify:Black Completed 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 10th Grade College (1-4 or 5+) Lincoln Conval CNA Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ Hester Perkins Harden Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4021 Rosecrest Ave., Baltimore, MD 21215 Rodney Johnson(son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/22/11 Baltimore, MD 4 Donation 5 Other (Specify) King Mem. Park 2703eghddrus of Brown Jr. 2140 N. Fulton Ave., Funeral Home Baltimore, MD 21. Signature of Euneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Case Acquired Pnysician/ Preumonia a Health da disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner with Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last executed Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnation
5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy Yes 2 N certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

within 24 hours after death.

To the Funeral Director: After this

Bombara

State

Medical

29a. Certifier

only one) 29b. Signature and title of certific

PGYZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Priyadiscoconathan, st. Agnes Haspital, 900s, caton Avenue,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P25483

29d. Date signed (Month, Day, Year)

Sep. 15,2011

Baltimore, MD 21229

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 29836 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Julia Derr Leah \mathbf{P}^{M} September 16, 2011 1:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Center 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) ine 5,1923 Days Hours 218-12-8450 Maryland Director June 1 M 2 X F 88 Yrs. Usual Residence of Decedent 28a-f shov 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at Director Baltimore Parkville MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 2505 Hillford Drive USA 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black White etc ō <u>}</u> 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Yes, Give Specify: white "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Supermarket Elementary/Secondary (0-12) College (1-4 or 5+) Cashier 12 other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ျ Mable V. Swift Page 1 and 2 should be George A. Soper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2505 Hillford Drive—Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Raymond Derr, Sr-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland Sept. 21, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ lebility disease or condition 4 cers 8 Due to (or as a consequent e of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit Exami that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy Po Month Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by b Concriec pais COPO 1 moush had lung disecte 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **V**No 2 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Matural Matural injury 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signaty and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 583 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST NN 701

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 29837 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0914 A M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Death **Examiner** 4c. County of Death altimore nocki Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year)
Dec. 19,1940 If Unde **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 💢 F Months 218-38-6438 Yrs. 70 **Director** Washington DC Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Prince George's Beltsville 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 12919 Forest View Dr. 20705 United States items a Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examin ō þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2XXNo Specify. White "natural", Specify: Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home of Health and Mental Hygie if item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dennis Calvin Simmons Stambaugh Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allan G. Dansie / Husband 12919 Forest View Dr., Beltsville, MD 20705 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
George Washington Cem. 9/16/2011 20c. Location - City or Town. State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Adelphi, MD 21. Signature of Funeral Vice Licensee 22 Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD mo15391 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ myo disease or conditi resulting in death) ard Medical Due to (or as a consequence of **Examiner** weak Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) CENTRICATION APPROVED BY NEDICAL EXAMINES sician and burial-transit Exami Cause (Disease or iinjury neart that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur and P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> SEGISE Records, Completed 2 No 3 Probably 4 Donknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 🖳 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examine ? P 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural
2 Accident 1 Yes 2 No Investigation 6 Could not be 28f. Location (Str. of and Number or Rural Route Number, UNJUUWMM . 3 ☐ Suicide 4 ☐ Homicide 28e. Place of 'njury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) munger vnnn Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signat

11-07002 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Susan Maria Davis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day September 16, 2011 Medical Examiner 2045 hrs Susan Maria 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours MD 218-94-4573 07/13/1966 M 2 X F 45 Country) Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a nr 28a-f shov must be notified at once. 1 X Yes 2 No Director Baltimore Turner Station MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 317 Pine Street 21222 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black Armed Forces? Never Married 2 XXMarried White etc 2 X No 1 Yes f Yes, Give Year 3 Widowed 4 Divorced Yes 2 No specify. Specify: **Black** ۵ ore, M,D 21215-0036
jes I and 2 should be filed within 72 hours of H-3alth and Mental Hygiene 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done leted 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical Compl Records Clerk MD State Government 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Garnett Parsons Lucille Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . ≥ item 27 is Theodore Davis/Husband 317 Pine St. Baltimore, MD 21222 Pages I and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, t: If it XBurial 2 ☐ Cremation 3 ☐ Removal from State crematory or other place) permit Page Department tant: 07 of Donation 5 Other Specify Holly Hill Mem. Grdns 9-23-2011 Middle River, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee James A. Morton & Sons F.H. Inc forton unes 1701-31 Laurens St. Baltimore, MD Rajipart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. /Medical Between Onset and a Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, JE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Year past 12 months? Dav Pregnant at time of Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. 23e. Did tobacco use contribute to the cause of death? É Parkinson's Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of page 2 performed? death? ✓ Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical of Vital 26.Place of Death (Check only one) Be examiner? Other Hospital: 1 Inpatient this 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 은 1 🗸 Yes No After 28a. Date of Injury Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification Sep 16, 2011 1 Natural Division 2008 hrs Pedestrian struck by auto death. Pending 1 Yes 2 ✔ No the 2 🗹 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide , or Town, State) North Point Boulevard, Dundalk, MD determined (Specify) Local Street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E.

State Registrar

DHMH 17 Rev 1/2001

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

September 17, 2011

OCIME

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year

		Please Typ	e or Print in					_	le.
	for State	•	ate of Maryla				Mental Hyg	giene	
	Registrar			Cer	tificate of L	Death		Reg. No	1 20020
Physician/ Medical	1. Decedent's Name (Fi	/ Middle, Last)	AILE	4			2. Date of Dea	PYS 20	1/ 273 JM
Examiner	4a. Facility Name (if not	institution, give street		ue	4b. City, Town, or	Location of Death	10)	4c. County of E	Death
Funeral	5. Social Security Numb		7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
Director	261-58-2 Usual Residence of D		28 F	6 Yrs.				1934 5	Carolina
and show dat		b. County	10c. (City, Town or Lo				20-0	10d. Inside City Limits
ne Maryland or 28a-f sho notified at	MD			altir	none				1 Yes 2 □ No
	10e. Street and Number	r and	λ. 20	0.4	10f. Zip Code	12		10g. Citizen of What	t Country?
leath with the items 23a cer must be	11. Marital Status	12. V	Vas Decedent Ever in	U.S. 13. \	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		American Indian,
after d after d xamin	1 Never Married	2 Married 1	rmed Forces? Yes No Yes, Give		Yes 2 No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify:	White, etc.
21215-0036 inthin 72 hours after r than "natural", o the Medical Exam Completed by	1	5. Decedent's Educati		16a. Deced	lent's Usual Occup	ation		16b. Kind of Busin	ess/Industry
I218	Elementary/Second	only highest grade co ary (0-12)	ollege (1-4 or 5+)	life. Di	O NOT use retired)	during most of work	ang	5-1 A	10000
nd 212 filed within filed within all Hygiene. I other tha went, the I BE Col	17. Father's Name (Firs	t Middle Last)			stodi		na (Eirst Middle	Maiden Surname)	1eade
larylane file should be file and Mental is marked of aumatic eve	John N	lom's I	Tones	SR		Nao	MIL	aurel	5
Baltimore, Maryland 21215-00 permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturary injury or other traumatic event, the Medical once. To Be Complete	19a. Informant's Name		/ / - \	19b. Mailir	. 11.11		D 14	; City or Town, State	1
and 2 s Health a	20a. Method of Disposi	tion	29	. Place of Dispo		iew Kal	Date Date	20c. Location - Cit	ZZS v or Town, State
imor Page 1 nent of ant: If it iry or o	Burial 2 0	Cremation 3 Remo	oval from State	cemetery, crem	natory or other place	91	23/2011		Mills MD
Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe once.	21. Sign Jure of Funera		3	21	. Mame and Addre	of Fluit	io Fav	word So	
m 88 5 6 8	-	8/8	SK	9 9	19854	OMC Acl.	Balto	MD 212	رحالا
	23a. Part 1. Enter the shock, or heart fa		ons that caused the de use on each be	eath. Do not ente	er the mode of dyin	ig, such as cardiac	or respiratory arr		Approximate Interval Between Office and Death
Medical	disease or condition resulting in death)	a	Due to (or 's a cons	equence of):	leror	s'c	Lido L	Ascula	vinas
Examiner	Sequentially list condi-	tions b -							
and al-transit	cause (Disease or inju	diate	Due to (or as a curs	eduer (e c'):					- 1
be executed ician and burial-transit	that initiated events resulting in death) Las	C	Due to (or as a conse	equence of):			·		
e be ex ysician ne buria		d							
Box 68760 death certificate be a trending physic ed for use as the b sician/Medica	IF FEMALE:	00-1							
ox 6 ath ce attend for us	23b. Was decedent pre in the past 12 mor	nths?	f yes, outcome of preg Live Birth 2 F Pregnant at time of	etal death 3 [Ectopic pregnand Other (specify)	су		23d. Date o Month	
the de ached	1 Yes 2 N 9 Unknown		Unknown						
ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate bar death. ector: After this certificate has been signed by the attending physiby the funeral director, page 2 should be detached for use as the tertificate: To Be Completed by Physician/Medic	Part II. Other significa	nt conditions contribu	uting to death but not	resulting in the u	ınderlying cause gi	ven in Part I.			te to the cause of death?
rds, equire equire hould hould									Probably 4 Unknown
Division of Vital Records, all or Attending Physician: The law requires s after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be I Certificate: To Be Completed I							24a. Was autop	sv prio	e autopsy findings available r to completion of cause of th?
/ital Reco	25. Was case referred t	o medical			26. P	lace of Death (Chec	perfo 1 Yes	2 No 1 L	Yes 2 No
f Vital Physician: this certific ral director,	examiner?	Hospi	tal: 1 lnpatient 2	☐ ER/Outpatie	nt 3 🗆 DOA Oth	er: 4 Nursing H	ome 5 Resid	lence 6 Other (S	Specify)
ion of tending Pheath. cor: After the funeral	27. Manner of Death 1 Natural 2 Accident	Pending 2	8a. Date of injury (Month, Day, Year)	28b. Time of injury	work		28d. Describe h	ow injury occurred	
ivision of or Attending P after death. Director: After t I in by the funers Certificate:	3 Suicide 6	Investigation Could not be	Be. Place of Injury - At	t home, farm, str		Yes 2 No	28f. Location (S	itreet and Number o	r Rural Route Number,
Divi	4 Homicide	determined	building, etc. (Spe	cify)			City or Tow		,
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: A completely filled in by the I Medical Certific	(Check 2	Certifying Physician Medical Examiner: C Certifying Nurse Pra	on the basis of examina	ation and/or inves	tigation, in my opini	on, death occurred a	at the time, date a	nd place, and due to	the cause(s) and manner stated.
To the within 2 To the comple	29b. Signature and title		2	MO	29c. Licens			29d. Date signed (M	
$lackbox{\bullet}_i$	30. Name and address	of person who comple	eted cause of death (It	tem 23a) (Type. F	Print)	38/	20	ego 1	5201/
101	31. Date filed (Month, I	UD B	B 89	39 B	prat	sen Bl.	vd a	on Bue	nig 406/
State Registrar		P 2 0 2011	Driver Solg	A. 40	ald	_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20c Per FH G919 9/20/2011 JH
State of Maryland / Department of Health and Mental Hygiene 29840 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 14, 2011 12:25 P M **DENNENBERG** Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3410 ASSOCIATED WAY, #112 OWINGS MILLS BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Months Hours Min. 0872271908 **Director** WI 392-38-4508 103 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3410 ASSOCIATED WAY, #112 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates WHITE "natural", Specify: 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ABRAHAM SHAPIRO ANNA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1706 JONES FALLS COURT, CROFTON, MD HARVEY DENNENBERG/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 X Removal from State Cudahy MILWAUKEE, 4 ☐ Donation 5 ☐ Other (Specify) AGUDAS ACHIM CEM. 09/19/2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ORONAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury Due to (or as a consequence of): and-tran that initiated events resulting in death) Last burialphysician the burial Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant was deceding the past 12 month No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 2 🔲 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Watural 5 Pending 1 🗌 Yes Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse P ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) es 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sube 54. 026 MAIN Leistaton 2. Registrar's Signature State

Registrar

			For State Registrar	State of Ma	aryland		artment of H r <i>tificate of I</i>		Mental Hy	giene Reg. Ne	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	29841
	Physici	an	1. Decedent's Name (First, Middle, La		-				2. Date of De Month	eath Day	y Year	3. Time of Death
100	/Medic	al	Richard B. 4a. Facility Name (If not institution, giv	Fones,	Jr.		4b. City, Town, or	Location of Dea	Depten		County of Deat	
200	and the second second	3	Future Care					Arnold				Arundel
	Funeral Director		220-18-8709	Gex 7. Age	e (In yrs. las 84	st birthday) Yrs.	Months Days Hours Min. (Month,			rth ay, Year) /1927	Coi	hplace (State or Foreign untry) MD
	/land low		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	e Mar Ba-f st	Director	MD Anne An	runde1			(len Bur	nie			1 □Yes 2√2 No
	with the a or 2 the no	Dir	10e. Street and Number 7237 Baltimore	Annonolia	D11		10f. Zip Code	21061		10g. Citi	izen of What Co	U.S.A.
	ems 23	Funeral	11. Marital Status	Annapolis 12. Was Decedent E Armed Forces?			Was Decedent of H If Yes, specify Cuba			0-	14. Race - Amer Black, White	rican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.	by Fu	12 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 N If Yes, Give Year or Dates:	lo		1 □ Yes 2⊠tNo		no moun, cro.,		Specify:	
21215-0036	72 hou natura lical E		15. Decedent's E (Specify only highest gra	ducation	I	16a. Dece	dent's Usual Occup	ation	orkina	16b. Ki	ind of Business/l	White
121	within and and the Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	kind of work done of DO NOT use retired Accou		orking		٨٥٥٥	unting
d 2	other other ent, th	Be Co	17. Father's Name (First, Middle, Last)			Accou		ame (First, Middle	e, Maiden		uncing
Maryland	ould be Menta larked latic ev	ToB	Richard B. Fone						red Merr			
Mar	id 2 sh Ith and 27 is m traum		19a. Informant's Name/Relationship (Mr. Edmund N. Ba		ısin	19b. Mailir	ng Address <i>(Street i</i> 7 Ferrer	and Number or F a Drive				ip Code) and 21787
Je,	of Heal		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of matory or other place	-	Date		ocation - City or	
Baltimore,	Page tment (tant: If jury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		1	don Pa	ark Cemet	ery 9/1	19/2011		-	Maryland
Ba	permit Depar Impor any In		21. Signature of Funeral Service Licer	iseo	M0135		2. Name and Addressingleton					Burnie, MD
			23a. Part1. Exter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir							BETVICE	Approximate Interval Between
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. DE	mE	2711	4 - ENI					Onset and Death
7	Examiner			Due to (or as a	a conseque	nce of):						
	De iti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterrying Cause (Disease or injury	b. Due to (or as a	a conseque	nce of):					_	
	execute n and al-trans	Examin	that initiated events resulting in death) Last	c Due to (or as a	a conseque	nce of):						
68760,	ficate be executed physician and s the burial-transit	edical		ь. d								
		/Med	IF FEMALE:	23c. If yes, outcome	of pregnance	ev.			-			
. Box	The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)			1	23d. Date of deli Month	very Day Year
<u>Р</u>	ires that the de signed by the a l be detached	Phys	9 🗆 Unknown	9□Unknown		i i- 4b		an in Dad I	one Did	A-b		the second death 0
ds,	luires the signer of the distance of the dista	by	Part II. Other significant conditions of CLOSTRIDIUS	•		•	, ,					the cause of death?
900 000	aw requir as been si 2 should I	Completed							24a. Was			topsy findings available
Vital Records,		Com							euto perf 1□ Yes	ormed2 2 No	death?	completion of cause of 2 ☐ No
Z.	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2∏Ei	R/Outpatier	nt 3 DOA Othe		eath <i>(Check only</i> Home 5 ☐ Res		C []Other (O	-76.1
Division or	ding Phy h. After thi funeral c	\vdash	27. Manner of D ath N Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 2	28b. Time o			28d. Describe			ony)
Sio	or Attendi after death. Director: A in by the fu	icatic	2 Accident investigation 3 Suicide 6 Could not b	e 290 Place of inju	ırv - At hom	e farm str	M 1 1	Yes 2 □ No	28f Location	(Street an	od Number or Br	ıral Route Number,
<u>></u>	s after al Direct	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	10, 10,111, 00	oot, taolory, omoc			wn, State		rai noute rvuniber,
٥,	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) Certifying Pt 2 Medical Example 1	nysician: To the best of miner: On the basis of and manner sta	examination	edge, deat on and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s) e, date and) and manner as d place, and due	stated. to the cause(s)
<i>)</i> '	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licenso				te signed (Montl	
	(1)		menegi	m.s				753		Sep	Kinter	15,201,
-	ン"		30. Name and address of person who	completed cause of de	eath (Item 2	(Type,	Print)	m.11-	1501,11.	,	2-2 2	158
	Sta Registr		31. Date filed (Month, Day, Year)	completed cause of de 32. Registra	s Signat	re	, , ,	nege		- 1 31	וויי עמ	
		5 T 1		MARKET TO THE PERSON OF THE PE								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician Substitute Park Models			State of Maryland / Dep	partment of Health and Nertificate of Death		21111	29842	
Submitted 18, 2011 Formula Directors Calchrist Edenter for Rospica Care Calchrist Center for Property of Submitted Center for Rospica Care Calchrist Cen						3. Time of Death		
Security Part Security Par				Susan Marie Francis			ber 18,	2011 ^{2:21} PM
Principle Prin	in the g				4b. City, Town, or Location of Death	4	4c. County of Deat	h
23.2 - 98-3/283 The Description of Park 100 mm 100 m						10.04.4(0.4)		
De State De Course De Cour	Z	Director		212-88-3263 1 □ M 2 🔀 F 47 Yrs.		(Month, Day, Year) Co	untry)
Angelo Finari San Information The Prince The Control of the		and show	roi		ocation			10d. Inside City Limits
Angelo Finari San Information The Prince The Control of the		Maryl 28a-f otifie	irec	MD Baltimore Parkvi	.lle			1 ☐ Yes 2 No
Angelo Finari San Information The Prince The Control of the		th the 3a or t be n	alD	10e. Street and Number		10g.		,
Angelo Finari San Information The Prince The Control of the		ms 2 must	ner			acifu You or No		
Angelo Finari San Information The Prince The Control of the	980	s after dea ral", or ite Examiner		1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 M No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
Angelo Finari San Information The Prince The Control of the	5-0	hour "natu dical	plete		edent's Usual Occupation	ing 16b.	Kind of Business	/Industry
Angelo Finari San Information The Prince The Control of the	2	hin 72 ne. than '	lmo:	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired)	nig		
Angelo Finari San Information The Prince The Control of the	2	ed wit Hygie other				o (First Middle Maide		lity
Test Test	lan	be file ental ked c					an Surname)	
State Stat	ary	hould and M s mai			ling Address (Street and Number or Rura	al Route Number, City	or Town, State, Zij	o Code)
Physician Phys	Σ	nd 2 sl salth a n 27 i		Naomi Funari /Mother 2	211 11th St. SE De	catur, AL	35601	
Physician Medical Examiner Physician	more	Page 1 ar nent of He int: If iten ry or oth		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, cre	ematory or other place)	Sep 22	*	
Physician Medical Exclinition Medical Exclinition Display Septiment Display Septimen	Balti	permit. Popartm Importa any inju	atives					
Physician Medical Examiner Part Medical Examiner Medical Examin				23a. Part 1. Enter the disease, or complications that caused the death. Do not er			wson Mary	Approximate
Sequentially list conditions, sequen	y.k.			Immediate Cause (Final disease or condition	ic Molenou	NEL		Onset and Death
FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Month Day	مميدي		<u>-</u>	Sequentially list conditions, b.				
FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Month Day		uted d ansit	amine	cause. Enter Underlying Cause (Disease or injury				
FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Month Day	_	oe execuician and	al Ex					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death? 1 yes 2 No 3 Probably 4 9 (Indiana suitable prior to completion of cause of death 1 yes	260	physics the	edic	d				
The state of the complete of the constraint of the date of the constraint of the con	-		ıysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5				
The state of the complete of the constraint of the date of the constraint of the con		s that th gned by be detar		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			
State Stat	rds	equire een s hould	eted			1 L Yes		
29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State State	Reco	The law r cate has b page 2 s	Compl			autopsy performed?	prior to death?	completion of cause of
29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State State	ita	ician certifi rector	Be	examiner?	Other:			11
29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State State	<u>></u>	Phys r this eral di		i inpatient 2 in Envolupati	ent 3 🗆 DOA 4 🗆 Nursing Ho			sify) Harpice
29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State State	nc Onc	nding ath. :: Afte e fun	cat	1 Natural 5 Pending (Month, Day, Year) injury	work?	zod. Bodombo mow mj	ary occurred	
29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State State	Divisio	al or Atte s after des I Director ed in by th		3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office			ral Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) APATHT KUNIAR C701 N CHARIFS ST SUITE LIDS BACTIMORE MD 212 State 31. Date-filed (Month, Day, Year) 32. Registrar's Structure	_	Hospit 24 hour Funera etely fille	edica	(Check 2 Medical Examiner: On the basis of examination and/or inve	estigation, in my opinion, death occurred at	t the time, date and pla	ce, and due to the	cause(s) and manner stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) APATHT KUNIAR C701 N CHARIFS ST SUITE LIDS BACTIMORE MD 212 State 31. Date-filed (Month, Day, Year) 32. Registrar's Structure		Fo the within Fo the complete	Σ					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) APATHT CUMAR 6701 N CHARLES ST SUITE 1:105 BACTIMORE MD 212 State 31. Date-filed (Month, Day, Year) 32. Registrar's Signature				> phate MA	D71040		9/10/	11
State 31. Date-filed (Month, Day, Year) 32. Registrar's Signature				30. Name and address of person who completed cause of death (Item 23a) (Type,			118.	(I
State Registrar SED 2 0 2011 Registrar's Signature				ARATHT KUMAR 6701 N CHA	LLES ST SUITE	4105 B	MITIA	RR MD 21250
				31. Date-filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 17, 2011 Physician/ 7:45P ELIZABETH CAROLINE FINCHAM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 13 Teresa Marie Court Millers Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 219-01-8318 90 **Director** 1 □ M 2**X.X**F 03/10/1921 South Carolina show. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 ☐ Yes 2 🔀 💢 🗸 28a-f Maryland Baltimore Millers 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 13 Teresa Marie Court 21102 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mu Was Dece Armed Forces? Vas XX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 XXIV Specify Specify: White 3XXWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Accounting Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Hoy Auvil Elizabeth Josephine_Fernandez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DTR Teresa Marie Court Millers. Patricia A Tierney Maryland 21102 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🕅 Sremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 09/22/2011 GreenMount Crematory Baltimore, Maryland Donation 5 D Other (Specify) ature of Funery 22. Name and Address of FMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease, or compli shock, or heart failure. List only o Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, n any, reading to maneurate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence on burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death been signed by the a should be detached P.0. art II. Other significant conditions ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy perforn 1 Yes 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No s after death. Medical Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 3 29d. Date signed (Month, Day, Year) 29b. Sidnature an 20071287

DHMH 17 Rev 06-2011

State

Registrar

SEP 2 0 2011

of person who completed cause of death (Item 23a) (Type, Print)
haheen, 6701M. Charles St. Suite 4(05, Balthwere, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Elizabeth Echelmeier Farrel1 5:45 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death N/A Union Memorial Hospital Baltimore . Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth Day, Year 28 1 □ M 2 🗓 F Months May 4 Hours 83 Pennsylvania **Director** 193-20-6393 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director Baltimore 1 Yes 2 X No Towson the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral with t 21286 IISA 1100 Ryegate Road Page 1 and 2 should be filed within 72 hours after death \u00fanto f Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner muyor or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗓 No δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Business Owner Floral Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Echelmeier Anna May Lapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Wells/Daughter 3683 N. 39th Street Boise, ID 83703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Sept. 2011 permit. Page Department of Important: If any injury or once. Atlantic Crematory 4 Donation 5 Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licensee Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Road Timonium, MD 210 Inc. Wichael J. 0 Klagle Timonium, MD 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sheek, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Acute liver Medical Due to (or as a consequence of) **Examiner** tisystem Sequentially list conditions, if any leaving cause. Enter Underlying Cause (Disease or linjury Exami requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown 1 Tes Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has I Hospital or Attending Physician; The law autopsy performed? 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Accident Investigation 1 Tes 2 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of eartifier 29d. Date signed (Month, Day, Year) AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD Memorial Hospital 201 E. University Union 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Naudain Francis, Jr. Sept 2011 6:50 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) **Director** 86 212-20-0605 1**X** M 2 □ F Oct. 18 1924 MD ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director MD Baltimore Monkton 1 Yes 2X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3900 Allendale Ct. 21111 death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc . or þ 1 Never Married 2 X Married 1 XYes If Yes, Give 2 🗌 No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X ☐ No Specify white "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Accounting 12 Accountant permit. Page 1 and 2 should be filed wii Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>th</u> once, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Christine Grace Muir Robert Naudain Francis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 Allendale Ct., Monkton, MD 21111 June B. Francis/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Removal from State cemetery, crematory or other place, Druid Ridge Cemetery 9/21/11 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Rd., TImonium, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 9.5 disease or condition Medical resulting in death) a a consequenc of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be de Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 1 🗌 Yes 2 No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Inpatient 2 ☐ ER/Outpatient this 27. Manner of Dea h 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending ours after death. leral Director: Af filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NW) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

A DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #1 PER PHY G119 9/20/2011 JH
State of Maryland / Department of Health and Mental Hygiene 29846 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
Raji Kumari Gupta 2. Date of Death 3. Time of Death September Physician/ 0215 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOP KINS onns altimore Social Security Number 9. Birthplace (State or Foreign Bunita) Kawlin 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗆 M 2 🔀 F Months 221-34-1808 0471271942 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Harford Bel Air Maryland 10e. Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21014 U.S.A. 423 E. Ring Factory Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔼 No or. 1 Never Married 2 Married Completed by be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: Specify: Indian 27 is marked other than "natural", traumatic event, the Medical Exa 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Department of Health and Mental Hy Important if item 27 is marked oth any injury or other traumatic encones. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bhaqwanti Dr. Bihari Mahajan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 East Ring Factory Road, Bel Air, Maryland 21014 (Spouse) Mr. Mohinder K. Gupta 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of uneral Service Licensee Testernan 22 Name and Address of Charles & Cremation Services - Bel Air (M01543) 3 Newport Drive, Forest Hill, Maryland 21050 Jeffrey R. (M01543)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between cholangih s Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, adding to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed?

1 Yes 2 No death? this certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital 2 X No မှ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director. After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 Laura 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St, Baltimore MD, 21287 Cappelli -aura 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 845 A Richard Earl Gentry 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN SQUARE HOSPITAL CENTER Baltimore Rosedale If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 1 **⊠** M 2 □ F Days Hours Min 05/14/1951 Virginia 214-56-3758 60 Yrs. Director Usual Residence of Decedent 28a-f shov 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Baltimore Middle River 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4010 Keeners Road U.S.A. 21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White Year or Dates. Vietnam Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Air Conditioning (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) Ventilation College (1-4 or 5+) Heating, Mechanic injury or other traumatic event, Be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Earl Leroy Gentry Eleanor Christine Daugherty should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Page 1 and 2 st Department of Health a Important: If item 27 is 4010 Keeners Road, Baltimore, Maryland 21220 Deborah Gentry (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 09/20/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Juneral Sance Licensee any Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ di ase or conum resulting in death) ase or condition Medical (or as a consequence of) Examiner BUSTOLE Gequentiany fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last ate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical MHTWOSLEWOTT DISTACT Division of Vital Records, P.O. Box 68760 IF FEMALE outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed certificate Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 💢 No ၉ After this c 1 Inpatient 2 KER/Outpatient 3 IDOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural Accider injury 5 Pending 2 🗆 No Accident Investigation after death

Director: A
d in by the f 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined thin 24 hours after the Funeral Dire mpleted filled in b City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is an examination and/or investigation. Medical 29a, Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complet only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAN

DHMH 17 Rev 7/2009

State

Registrar

SEP 2 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 724 Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death Examiner Zimpre hdid Dan If Under 24 Hrs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2🏋 F Months Days May 1.5 , 1923 Maryland 215-12-2530 88 Director Usual Residence of Decedent show 10b. County and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10a State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No Baltimore MD Citizen of What Country? 10e. Street and Number 10f. Zin Code 21207 Funeral 6811 Campfield Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 7 Black, White, etģ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) social worker social work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cora Alice Custer John Robert Hipsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2444 Rosemore Ave; Glenside, Pennsylvania 19038 Lisa D. Guth - daughter Page 1 and 2 Baltimore, 1 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Ser 22. Name and Address of Facility State Anatomy Board Ronald Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No signed by the atte Month Day Year Pregnant at time of death 1 ☐ Yes 2 D 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No ၉ 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? Natural 5 Pending hours after death. neral Director: Aff d filled in by the fur 2 🗌 No Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month 3:17 P M 2011 September Beulah Louise Goldsmith Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Catonsville Frederick Villa if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July 28, Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday **Funeral** Days Hours 1924 **Director** 230-26-4845
Usual Residence of Decedent 1 M 2 XF 87 Yrs. Virgina 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f shoner must be notified at Director 1 Yes 2 No Maryland Howard Elkridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21075 United States 6391 Rowanberry Drive Apt#407 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or iter edical Examiner Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify If Yes Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ Eva Crowther Charles Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 7885 Brighton Court, Pasadena,Maryland 21122 William Goldsmith, III/ Son 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Sept. 17,201 Glen Burnie, Maryland me and Address of Facility AMBROSE FUNERAL HOME, INC. 21. Signature eral Service Licensee 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, Immediate Cause (Final Derevtia Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury for use as the burial-tran attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the and to be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 💆 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has I autopsy death? performe 1 Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 × No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Dav. Year) 247 2011

Registrar DHMH 17 Rev 06-2011

State

31 Date filed (Month, Day, Yea

haltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signa

State Registrar 29b. Signature and title of certifier

DANIEWE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

DOBERMAN,

CEOAR

LANE

COLUMBIA, MD

6336

29d. Date signed (Month, Day, Year) SEPTEMBER 15, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 13. 2011 5:43 AM HOWARD R GREENHOUSE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ARDEN COURTS BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Days Hours 08/11/1925 Director 130-14-7859 86 Usual Residence of Decedent 28a-f shov at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 XNo MD BALTIMORE REISTERSTOWN 10g. Citizen of What Country? 5 10e. Street and Number 10f. Zip Code 23a Funeral 3 PLEASANT BROOK COURT 21136 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 X Divorced Specify: Completed WHITE Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ARCHITECTURE ARCHITECT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked or မ GREENHOUSE BOBROWSKY HYMAN ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t and 2 sl of Health a item 27 i ALISON FELDSTEIN/DAUGHTER 3 PLEASANT BROOK COURT, REISTERSTOWN, MD 21136 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or of 1 🕅 Burial 2 🗆 Cremation 3 🕅 Removal from State 4 Donation 5 Other (Specify) ARLINGTON NATIONAL 09/26/2011 FT. MYER, VA. Funeral Service Licensee 21. Signature 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final - h, sician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or impury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 L Yes 2 L 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 😿 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy eral Director: After this certificate I filled in by the funeral director, page 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Fother (Specify) Ass 3/e Living 2 No 1 Yes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charle

6701

Black

31. Date filed (Month

DO061199

. Svite 4105 Touson ms

Sept. 13 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Oak Crest Village Care Center Parkville 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign $\overset{C}{\mathbf{N}}\overset{C}{\mathbf{Y}}$ 8. Date of Birth **Funeral** Hours Min. 1 M 2 X F 219-07-5045 1077471918 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Parkville MD Baltimore 1 Yes 2X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a USA 21234 8832 Walther Blvd. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or ģ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify "natural" Completed Specify: White 3 X Widowed 4 Divorced al Hygiene. d other than "natura event, the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Education 12 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ပ Amelia Thomala Vincent Mullin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traconce. Amy Jenkins / Daughter 5529 Edwin Court, White Marsh, MD 21162 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Harford Mem. Gdns.9/23/2011 Aberdeen 4 Donation 5 Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home 333 S. Parke St. Aberdeen, Signatura P.A 4D 21001 Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or lingury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) Pregnant at time of death ☐ Yes 2 ☐ Unknow been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has l page 2 s performed? certificate 2 🗆 No 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hame and address of pa son who completed cause of death (Item 2

DHMH 17 Rev 7/2009

State

Registrar

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month. 17:16 FM Physician/ 6 15 ete moir Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Ra HOPPINS more N/A 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F Days Months July 4, 1962 49 Montana Director 517-56-7716 Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at anotes. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No Yellowstone Billings Montana 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 59105 2052 St. Andrews Drive USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X No Specify Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Banking C.P.A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carol M. Forsythe James S. Cotton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Hall, Husband Andrews Drive Billings, MT 59105 2052 St. 20a. Method of Disposition
1

Burial 2

Cremation 3

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Metro Crematory Inc. 09/16/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licens Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death MMONAY Ph sician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** OUT Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5 Pending 2 🗌 No 1 Yes Investigation within 24 hours after death

To the Funeral Director; A Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St

State Registrar a

. Registrar's Sign

en

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Highsmith Shelton D. 09 14 2011 8:00a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3213 Ferndale Ave Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Hours Min 06 28 213-32-8243 **Director** NC Usual Residence of Decedent 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits Director must be notified MD NA Baltimore 1 Xyes 2 No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 3213 Ferndale Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X/es 2 No
If Yes, Give
Year or Dates. Black, White, etc ö þ 1 Never Married 2 X Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🔀 No Black "natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Carrier Central Delivery 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Samuel Highsmith Mattie Mae Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health a Baltimore, Md 21215 Emma Highsmith-Wife Ferndale Ave, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date of ± 5 Burial 2 Cremation 3 Removal from State Important: It any injury or 4 ☐ Donation 5 ☐ Other (Specify) 9/22/2011 Garrison Forest Owings Mills, Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md Part / Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ myspath Medical Examiner Sequentially list nonclitions if any, leading to immediate cause. Enter Underlying Physician/Medical Exam Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death g ☐ Unknown Month g Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 N Division of Vital completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After injury work? 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6095 Marshalee

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

N'Coel Vandoi	а Но	otate of Maryland / Depart	ment of ficate of	Health and Mei		2011	29855
Physic Medical Exar		Decedent's Name (First, Middle,Last)			2. Date of De	eath	3. Time of Death
Wedical Exal	mie	N'Coel Vandora Horton 4a. Facility Name (if not institution, give street and number)		b. City, Town, or Location	Septemb	Day Year Der 14, 2011 4c. County of Deat	0753 hrs
		Johns Hopkins Hospital		Baltimore	o, Boatt	N/	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)			Birth (MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Directo		167-98-0044 _{1 M 2XF}	Yrs.	Months Days Hour	s Min. 7/24		untry) MD
kus		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location	on			10d. Inside City Limits
bud show		MD N/A Bal	timo	ce			1 X Yes 2 No
te Maryland or 28a-f show any fied at once	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	ntry?
th the 23a or	ם ת	907 E. Preston St.		21202		USA	
ath wi	uneral	11. Marital Status 1 X Never Married 2 Married Armed Forces?		Decedent of Hispanic Ori s, specify Cuban, Mexicar		o- 14. Race - Ameri White, etc.	can Indian, Black,
fter de 1", or	×	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2X No specify	:	Specify: Bla	ck
nours a natura Exami	Completed by		a. Decedent	s Usual Occupation (Give st of working life. DO NOT	kind of work done	16b. Kind of Business/I	
36 in 72 i han "	plet	Elementary/Secondary (0-12)	N/		use retired)	N/A	
d with ygiene other t	E	17. Father's Name (First, Middle, Last)			r's Name (First, Middle,	Maiden Surname)	
215 Pe file riked of	Be	James Rouzer			evana Hor		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "statural", or items 23a or 28a-f sho injury or other transmitic event, the Medical Examiner must be anotified at once	은	19a Informant's Name/Relationship (Type, Print) Viola Horton-Grandmother	9b. Mailing	Address (Street and Nur	nber or Rural Route Nu	mber, City or Town, State	Zip Code) 21202
and 2 lealth item 2				on (Name of cemetery,	Date	20c. Location - City or	
Baltimore, permit. Pages I an Department of Heal Important: If iten injury or other tra	1	Cros	natory or other	erplace) it Cemt.	9/19/201	Baltimore	*
altir mit. P partme portan		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee				/H 1101 E.	
	L	Synette Ko Jones	Ave	. Baltimo	re, MD 21	202	1102011
Physician Medical		23a. Part I. Efter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the	mode of dying, such as c	ardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Bronchopneumonia Due to (or as a consequence of):					Death
		Sequentially list conditions, b					
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause					
pa pait isit	Examiner	(Uissass or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
O, the executed sician and purial - transit	dical	MENDED AMENDED 23a,27, per	me,g	923 1-31-12	SM		
60, ate be oblysical to burise	Med	IF FEMALE: 23c. If yes, outcome of pregnance				23d. Date of delivery	
OX 6876(ath certificate attending phys	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 1 Pregnant at time of death	2 Fetal	death 3 Ectopic	pregnancy	,	ay Year
Box 68760 e death certificate by the attending physical for use as the bu	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	5 Othe	r (Specify)		1	
0 - 0	by Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the und	derlying cause given in Pa	rt I. 23e. Did to	obacco use contribute to t	he cause of death?
Division of Vital Records, P.O. In or Attending Physician: The law requires that the rest after death. The Individual Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed b				1 Ye		ably 4 Unknown
cords law requi has been	Completed				24a. Was	osy prior to co	opsy findings available empletion of cause of
Vital Rec ysician: The l his certificate l director, page		05			1 Yes	rmed? death? 2 No 1 ✓ Yes	2 No
/ital /sician /sician /sician /sician /sician	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/C	Outpatient	26.Place of Death (Residence 6 Other:	
of \ng Ph;	n: To	27. Manner of Death 28a. Date of Injury 28b.	Time of Inju			how injury occurred	
Sion ttendi death. ctor:	atio	Natural 5 Pending 2 Accident Investigation		1 Yes 2			
Divis	Certification:	3 Suicide 6 Could not be determined (Specify)	arm, street,	factory, office building, etc	28f Location (S or Town, S	Street and Number or Rura state)	al Route Number, City
Hospital A hours a Fuoeral I ely filled		29a. Certifier	eath occurre	d at the time, date and pla	on and due to the serve		
Divis To the Hospital or A within 24 hours after To the Fuornal Dire completely filled in b	Medical	(Check only Certriying Physician: 10 the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation	n, in my opinion, death occ	ce, and due to the caus curred at the time, date	and place, and due to the	cause(s)
2 H 2 H 2	¥	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mont	h, Day, Year)
W		Pungat Trushell, mis		O.C.M.E.		September 15, 20	11
4		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examine		V. Baltimore Street	Baltimore MD 2	1223	
		31. Date filed (Month, Day, Year) 32. Registrar's Signature					
Regis	rar	SEP 2 0 2011 Sever S. par					

8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) NY 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, Specify: Black 16b. Kind of Business/Industry N/A 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5914 Falkirk Rd. Balto., MD 21239 20c. Location - City or Town, State Baltimore, MD 22. Name and Address of Facility March F/H 1101 E. North . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes 2 No Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene 28d. Describe how injury occurred Hospital or Attending Certification Division 24 hours after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 12, 2011 104 Dav 30. Name and address of person who completed cause of death (Item 23a) 0 Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, SFP 2 0 20 32. Registrar's Signature Registrar

0235 hrs

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2118 Physician/ 2011 ORIA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Linthicum Heights Tate Hospice House If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Country) 1 M 2 0770971944 PA Director 216-42-0929 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland notified at Director 1 Yes XX No Anne Arundel MD Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 0 Funeral USA permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important; if item 27 is marked other than "any injury or other traumotic." 21061 401 Joyce Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes XX No Specify. White 3 Widowed XX Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Towson University Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Polcha Eleanor Veronica Palumbo Joseph John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter Baltimore, MD 21224 644 S. Decker Avenue Ms. Catherine E. Holland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial XX Cremation 3 Removal from State 9/20/2011 Glen Burnie, MD Atlantic Crematory 4 Donasion 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Sign of Fune of Sign e Licensee Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 01220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final /ARI AN Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? has death? certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be B examiner? Other: 2 1 Yes 2. No 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 I To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License numbe 29b. Signature and title of certifier

\$

State Registrar

SEP 2 0 2011 Seman S. Jak

Defonse Huy ANNApolis 412 244

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G919 9/20/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2011 08:00 P M 12, Catherine Over Hutson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air 1358 Saint Francis Road If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Baltimore Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 00 **Funeral** July 26, 1926 1 □ M 2**X**) F Months Days 85 219-20-7386 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at death with the Maryland Director 1 🗌 Yes 2 🔀 No Carney Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3 items 23a Funeral U.S.A. 21234 9422 Ridgley Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Margaret Schmidt John M. Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1358 Saint Francis Road, Bel Air, Maryland Mrs. Joan Fike (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Evans Funeral Chapel 14, 1 Burial 2 X Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey R. Testeman 22. Name and Address of Facility Ewans Funeral Chapel & Cremation Services — Bel Air Testernan (MO1543) 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or locart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Endstage Physician/ Demonte 400 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 2 No 1 ☐ Yes ∠ ≡ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Insufficency page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Tes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Daughter's examiner? Hospital Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6XXOther (Specify) Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work 5 Pending 1 Tyes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31295 person who completed cause of death (Item 23a) (Type, Print) 9 Floes2 5701 Buttimere ~0 Kenwood nth, Day, Year) 31. Date filed gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #3 Per PHY 6919 9/26/2011 Jh State of Maryland / Department of Health and Mental Hygiene 29859 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10g04pmh Physician/ September Anne Margaret Hale 7047 M 7011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 110 Heritage Lane Sykesville Carroll Social Security Number 8. Date of Birth (Month, Day, Year) Aug 19, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign Hours Min 1938 New Jersey 73 Director 461-25-6117 1 M 2 F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 110 Heritage Lane 21784 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Office Setting Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Talbot Schroeder Margaret Villanella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Whitaker /Sister 110 Heritage Lane Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sep 15 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Nactath attron Family Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ can cer Luny disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 1 Yes 2 9 Unknown Pregnant at time of death 5 Other (specify) Dav Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MsRijapanen.D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MO 21209 N.S Rajapakk, M.D 5703 2835 Smin AV 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 20

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept Physician/ Hasenzah 2011 0822 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville haclestown 8. Date of Birth (Month, Day, Yea Jan. 23. 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 □ M 2 🔀 F 212-09-2297 Director 1919 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director PA York Red Lion 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 461 Garden Court 17356 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc o <u>≥</u> 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto Obst Margaret Kirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Dalrymple Daughter 17356 461 Garden Court; Red Lion, PA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 9/20/2011 Woodlawn, MD Donation 5 D Other (Specify 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signa ure of Funeral Service Lice is 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Dementa Physician/ Endstage disease or condition resulting in death) Medical Due to (or a a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
g ☐ Unknown Month Year Day 4 Pregnant Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Tyes Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 📈 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) CRMP R144682 Sept 16, 2011

Registrar

State

709

Maiden

31. Date filed (Morth 1944) Year)

Catonsville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

anc

Cho; ce

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

		•	For State Registrar	State of Ma	aryland		tificate of L			Reg. No		29861
	Physicia	ın/	1. Decedent's Name (First, Middle, Last						2. Date of Dea Month		18, 2011	3. Time of Death 3:20 A M
-	Medic Examin		Gertrude Violet 4a. Facility Name (if not institution, give:		_		4b. City, Town, or	r Location of Death		$\overline{}$. County of Death	
med.	LXamiii		801 N. Woodlynn Ro	ad			Essex				Baltimo	re
	Funeral Director		5. Social Security Number 217-03-1643 Usual Residence of Decedent	7. Age	(In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 04/17/	h (, Yea <i>r)</i> 191	9. Birth Cou Mass	nplace (State or Foreign ntry) achusetts
	and show lat	or	10a. State 10b. County		10c. City,	Town or Loc	ation		·			10d. Inside City Limits
	Maryl 28a-f otifie	irec	Maryland Baltimor	e	Ess	sex						1 🗌 Yes 2 🔼 No
	s 23a or nust be n	Funeral Director	10e. Street and Number 801 N. Woodlynn Ro	ad			10f. Zip Code 2122	21		-	S.A.	untry?
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Exammed Forces? 1 Yes 2 X If Yes, Give Year or Dates.			Vas Decedent of H Yes, specify Cuba	Ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		14. Race - Amer Black, White Specify: W	
21215-0036	thin 72 hour ene. than "natu he Medical	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12) 10			(Give k	NOT use retired)	during most of wor	1		rd of Ed	
Maryland 2	i be filed wi fental Hygid rked other tic event, t	To Be (17. Father's Name (First, Middle, Last) Nelson Sylvester F	rink	I_	Cusco	<u>carair</u>	18. Mother's Nar Lethade	ne (First, Middle,	Maiden	Surname)	deactori
	and 2 should Health and N tem 27 is ma		19a. Informant's Name/Relationship (Ty Darleen Kobal (Dau					and Number or Ru S Avenue,				
ore,			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		cen	netery, crem	sition (Name of patory or other place		Date		ocation - City or	
Baltimore,	permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fune al Service License		Gard	22.		tiźdz Insk	i Funera	ıl H	ome, P.A	
	o a i i i		23a. Fart 1. Enter the disease, or comp	olications that caused	the death.						ex, Mary	rland 21221
	Physician/ Medical		shock, heart failure. List only or Immediaty Cause (Final disease or condition resulting in death)	a. Due to (or as a	080	nar	1 0	Nery	dife	Cr	e	Interval Between Onset and Death
-	Examiner	<u>.</u>	Sequentially list conditions	b				3.5				
	rted d ansit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a	consequer	nce of):						
Q	icate be executed physician and s the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as a	consequer	nce of):						
68760			IF FEMALE:	00 1/	,					- 1		
Box 6	Hospital or Attending Physician: The law requires that the death certifics 24 hours after death. 24 hours after death. 25 hours after death. 26 hours after death. 27 hours after death. 28 hours after death after this certificate has been signed by the attending page 2 should be detached for use as the filled in by the funeral director, page 2 should be detached for use as the filled in by the funeral director, page 2 should be detached for use as the filled in by the funeral director.	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal c	death 3	Ectopic pregnand Other (specify)	су			23d. Date of deli Month	very Day Year
ls, P.O.	uires that the deans is signed by the and the		Part II. Other significant conditions co	ontributing to death bu	it not result	ting in the u	nderlying cause gi	ven in Part I.				the cause of death?
Division of Vital Records,	The law require cate has been si page 2 should b	Completed by							24a. Was a autop perfo	osy rmed?	death?	opsy findings available ompletion of cause of
la F	cian: The ertificate ctor, pag	Be C	25. Was case referred to medical examiner?					lace of Death (Che		- <u>/</u> -		
Ţ	Physici this cerral direc	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		R/Outpatien	t 3 DOA Oth	4 ☐ Nursing F	lome 5 Resid		6 Other (Speci	fy)
o uc	nding lath. r: After e funer	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,		injury	work		200. Describe II	iow injui	ry occurred	
Divisio	To the Hospital or Attend within 24 hours after death To the Funeral Director: A completed filled in by the f	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			e, farm, stre	et, factory, office		28f. Location (S City or Tow		nd Number or Run e)	al Route Number,
_	Hospit 24 hour Funera eted fille	Medical	(Check 2 Medical Exami		amination a	and/or invest	igation, in my opini	on, death occurred	at the time, date a	nd place	e, and due to the c	ause(s) and manner stated.
_	To the within 2 To the comple	Σ	only one) 3 ☐ Certifying Nurs 29b. Signature and title of certifier	or ractioner: to the t	JUST OF HIS K	owieuge, 0	29c. Licens	e number			ate signed (Month	
	•		30. Name and address of person who	Simpleted sources (20) (Time 17	rint)	1237	1	9	119/1	
)			SHVITITA SHIV	ANAMA	1121	+ ma	Le Ave	Back	more	M	10 212	121
	Sta Registra		31. Date filed (Month, Day, Year) SFP 2 0 2011	/2. Registra	r's Signatur	bar	KN					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29862 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month September 2011 10:40 AM Karen Jean Hargis 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 9927 Middle Mill Dr. Owings Mills Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 23, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) . Year) 1941 Hours Months Days Oklahoma 1 □ M 2 🗓 F 585-10-2200 70 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Owings Mills Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21117 9927 Middle Mill Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) healthcare nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lahoma Ernistine Gatlin Home Eloyd South 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jack Nugent - friend 9927 Middle Mill Dr; Owings Mills, MD 21117 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Ronald Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): BRONCHIECTASIS Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last KARTAGENER SUNDROME Due to (or as a consequence of)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

ģ

Completed

Be (

ဂ္

ner

Examir

Physician/Medical

þ

Be Completed

Certification: To

Medical

SPYRIDON

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician the nse for 1 ned by the signed has certificate this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 100 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3 ☐ Ector	pic pregnancy r (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyi	ng cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
RHEUMATOI	D ARTHRIT	20		_ 1 □ Yes	2 No 3 Probably 4 Unknown
				24a. Was an autopsy performe 1 □Yes 2 [
25. Was case referred to medical			26. Place of D	eath (Check only one)	
examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3 [] DOA Other: 4 ☐ Nursing	g Home 5 🗗 Residen	ce 6 ☐ Other (Specify)
27. Manner of Death 1 Antural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fac fy)	ctory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	nysician: To the best of my kninner: On the basis of examinand manner stated.				use(s) and manner as stated. e and place, and due to the cause(s)
29b. Signature and title of certifier			29c. License number	290	d. Date signed (Month, Day, Year)

D0057757

State Registrar

MD GOIN. CARDLINE ST BATMORE, MD MARINOPOULUS 31. Date filed (Month, Pay, Year) SFP 2 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death nt's Name (First, Middle, Last) 2. Date of Death September Physician/ 18 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner balt more JOHNS HOPKINS 1+059.+9 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Hours Min 215-30-076 Yrs. Director 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral · death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever II U.S 14 Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 M Married ≥ Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed ac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. De NOT use retired) artment of Health and Mental Hygiene. octant: If item 27 is marked other than injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Maiden Surname ဂ a 19a. Informan me/Relationship (Typę Rural Route Number, City or Town, State, Zip Code) 21216 Department of Health a Important: If item 27 is any injury or other traces IVIA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State emetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) ElKridge Signature of Funeral Service eene Funeral MD21133 ROA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac errespiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RAIN HORNIATION disease or condition) Medical resulting in death) Due to (or as a consequence of) **Examiner** TROKE Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician ause as the burial-Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year 5 Other (specify) Day be detached ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law r 24 hours after death.
 Funeral Director: After this certificate has b autopsy page 2 . Yes 2 1 **Division of Vital** completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 Tyes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending iniury 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 E. only one 29b. Signature and title of dertifier 29d. Date signed (Month. Day, Year) MO. PHD 1 Miltz death (Item 23a) (Type, Print) 30. Name and address of person who comp DV Wolfe Balt-more MD 2118 600 BUTTOGO BLALCO 32. State 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 6 Day 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month O Year Physician/ 011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner **Baltimore Bon Secours Hospital** If Under 1 Year 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Country) 1 🗆 M 2 🗶 F Months Days Hours Min MD (Month, Day 1 Year) 40 220-38-6505 70 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits

X
Yes 2 □ No 10b. County at 10a. State 10c. City, Town or Location with the Maryland Director **Baltimore** be notified MD **Baltimore City** 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? 23a 21217 U.S.A. Funeral 2132 Division Street **Examiner must** items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 0 1 Never Married 2 Married <u>Ş</u> Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working within 72 | permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiers Importants if item 27 is marked other than any injury or other traumeth. life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) **Day Care Provider Own Home** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Hazel Gardiner** 2 Scottie Gardiner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2132 Division Street Baltimore, MD 21217 19a. Informant's Name/Relationship (Type, Print) Tachaia Haughton Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Metro Crematory, Inc. Catonsville, Maryland Sep 24, 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Signature Funeral Service Licensee Part 1 Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed physician s the burial Physician/Medical Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ed by the atter detached for u in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death 9 🗌 Unknown P.O. signed by t Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records. Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy has certificate Division of Vital 25. Was case referred to medica director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours after uses...

he Funeral Director; After this of an other filled in by the funeral di ည 1 Npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1⁴ ★ Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p 4660 Wilkens mariam 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 2 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 29865 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 12, 2011 James Francis Hubbard 2:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4924 Eastwood Place Howard Ellicott City If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😿 M 2 🗆 F Hours July 20, Year 930 Mary Tand 213-28-9286 81Yrs. **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at the Maryland Director 1 Yes 2 X No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral with 4924 Eastwood Place 21043 United States death items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iten edical Examiner r Armed Forces? 120ct53
It Yes 2 No 20ct53
If Yes, Give Year or Dates. Black, White, etc. þ 1 X Never Married 2 Married 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examitury or other traumatic event, the Medical Examit Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leo Hubbard Mary Elizabeth Hayes 19a. Informant's Name/Relationship (Type, Print)
Mark F. Hubbard/ Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1523 Fountain Glen Dr., Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery Sept.20,2011 Baltimore, Maryland 22. Name and Address of FacilitAMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COCONON Ph_sician/ disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, Examine daily, leading to immedia cause. Enter Underlying ed by the attending physician and detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rede Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knewledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of e mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: hest o 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10298B Batto. Next 1. Pike Ellicott City Med e of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of perso

SEP 2 0 2011

Charles Date filed (Month, Day, Year)

Sheehan M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ I6, SEPTEMBER DORIS HORTON 20T1 9:20 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD FOREST HILL FOREST HILL HEALTH & REHAB CENTER Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🗆 M 2 💢 F JUNE 23, 1921 Country) Director 181-12-1492 PA Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD HARFORD 1 🗆 Yes 2 😾 No JOPPA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 328 RED HAVEN CT 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 0 Black, White, etc. 1 Never Married 2 Married 2 **XN**0 Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN HORTON MYRTLE MCINTOSH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHYERL SCHWANDINER-NIECE 328 RED HAVEN CT JOPPA, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s Department of F Important: If ite 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) BRIDGEPORT CEMETERY 9/22/11 BROWNSVILLE, PA 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELAIR Signature of Funeral Service Licenses 610 W.MACPHAIL RD BEL AIR. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ on DS Mage Demental disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death 2 🗌 No ned by the g 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, an-m.a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No page 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number Daugh 5 D D32277 Sepromber 15 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. DAVID DUNN MACPHAIL ROAD 21014 BEL AIR, MD. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

SEP 2 0 2011

Box 68760

Division of Vital

acks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2 Date of Death September 14. Physician/ 2011 Harry Aloysius Horstman, Jr. 11:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Carriage Hill Bethesda Montgomery 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, 1 🔀 M 2 🗆 F Days Hours Min Washington, D.C. 1916 Director 578-18-1273 95 June Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Page 1 and 2 sho. Id re filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No |Maryland| Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 United States 5215 West Cedar Lane items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or 1 Never Married 2 Married Completed by Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates WWII ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Physician Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n arked မ of Health and Menta item 27 is n arrectorher traun atic e Anna Evelyn Rileigh Harry Aloysius Horstman, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6817 Newbold Drive, Bethesda, Maryland 20817 Karen Kamerick/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. cemetery, crematory or other place)
Montgomery
Crematorium. Inc. ☐ Burial 2 X Cremation 3 ☐ Removal from State September 17, 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland 21. Signatura of Funeral Service Lices 22. Name and Address of Facility.

Bethesda—Chevy Chase, Inc. Harm M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertensive Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Atrial Fibrillation Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Due to Earles a consecuence of the Hospital or Attending Physician; The law requires that the death certificate be executed Coronary Heart Disease burial-tran Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Records, P.O. Box 68760 ast IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 X No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 🔀 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Af 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination alrayor investigation, it may opinion, weath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) NUMBUL V JWOMUS September 15, 2011 D0047330 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 West Edmonston Drive, Rockville, Maryland 20850 M.D. Thomas Joseph,

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #26 Per PHY G919 9/20/2011 JH

State of Maryland / Department of Health and Mental Hygien 2 0 1 2 9 8 6 8

			State Registrar			Cer	tificate	of D	eath			Reg. N	10.		
	Physicia	ın/	1. Decedent's Name (First, Middle,	Last)				-			2. Date of De)av Vo	ar	3. Time of Death
	Medic			Jenkins							Septemb	er 1	Î, 201Î	ai	11:15 A. ™
	Examir	er	4a. Facility Name (if not institution,		per)		, ·		Location of			4	c. County of [
	Francis			herville 6. Sex 7	7. Age (In yrs. last	hirthdayl	If Under 1		erville		8. Date of Bir	th.	Baltim		lace (State or Foreign
	Funeral Director		213-76-0389 Usual Residence of Decedent	1 □ M 2 XX F	91	Yrs.		Days	Hours	Min.	Month, D	8, Yea 1	920		Scotia
700	show	ō	10a. State 10b. County		10c. City, To	own or Loc	ation							10	Od. Inside City Limits
April	8a-f	Director	Maryland Balti	more	В	altimo	re								1 🗆 Yes 2 🛣 No
tith the	positive rage; and 2 subusing the properties are death with the way yand population to get an 2 subusing the properties of the part and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Di	10e. Street and Number 6001 Altamont Pla	ice	<u> </u>		10f. Zip C	Code	21210)		109. 0	Citizen of What Country? USA		
4004	items items ier m		11. Marital Status	12. Was Deced		13. V	Vas Deceder Yes, specify	nt of His	spanic Origin	n? (Spec	cify Yes or No-		14. Race - A		
21215-0036	ural", or	ted by	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ied 1 Yes If Yes, Give Year or Date	2 🗓 No		Yes 2			rueito i	ncari, etc.)		Black, V Specify:		ite
5-6	"nati	Completed	15. Deceden (Specify only highes	t's Education st grade completed)	[]	(Give k	ent's Usual I	done du	tion uring most o	of workin	ng	16b.	Kind of Busin	ess Ind	lustry
121	than	ĕ	Elementary/Seconday (0-12)	College (1-4	1 or 5+)	life. DO	o NOT use re emaker	etired)	g				Own Home	2	
S S S	Hygie other ent, tl	Be (12 17. Father's Name (First, Middle, La	ast)		11(A1)	dianci	т.	18 Mother	's Name	(First, Middle,				
ylan	Mental narked natic ev	၀	Leslie W. N	lauss					Maria	a Ann	a Rafuse)			
Baltimore, Maryland	tance should be made the standard of the standard temperature of the standard control of the standard		19a. Informant's Name/Relationshi Candace Shaffer	ip (Type, Print) Daughter		19b. Mailin	g Address (\$ 1709 Wi	Street ar 11ow	nd Number Avenue	or Rural e, T	Route Number	r, City o aryl	or Town, State Land 2120	, Zip C)4	ode)
more	nent of H nent; If ite iny or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.		State cem	etery, crem	sition (Name hatory or oth e Cemet	er place		₀ 17/2/	ate 011		Location - City		
Balti	Departn Importa any inju		21. Signatur o Funeral Service Li	censee	1/	Bu 36	Name and	Address	of Facility Seitz I	Funer	al Home, re, Mary	Inc	2121		
		Н	23a. Part 1. Enter the disease, or o shock, or heart failure. List or	complications that ca	used the death. D										Approximate
⊸. Pŀ	n sician/		Immediate Cause (Final	ily one cause on each	h line.										Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (o	r as a consequenc	ce of):								+	
E	xaminer		Sequentially list conditions,	h											
73		ine	if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consequent	ce of):									-
scuted	and trans	Examiner	that initiated events resulting in death) Last	C. Duo to /s	r as a consequent	20 of:								-	
e exe	ician	al	resulting in death) East	Due to to	i as a consequent	ce oi).									
58760 ertificate b	phys the l	/Medical I		d								_		\pm	
- %	been signed by the attending physician and should be detached for use as the bunal-transit	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live B	ome of pregnancy irth 2 Fetal de ant at time of deat own	eath 3 🗀	Ectopic pre Other (spec		′				23d. Date of Month		ry Day Year
P.O.	gned by oe detac	by Ph	Part II. Other significant condition	-	ath but not resultin	ng in the ur	nderlying car	use give	en in Part I.						e cause of death?
ds,	sen si	ted	ALZHEMER'S D	EMENTIA							1 🗆	Yes :	2 □ No 3 □	Prob	ably 4 Unknown
Records, P.O. Box The law requires that the death of	te has be	omple									24a. Was auto perfo	osy ormed?	prior deat	to cor h?	sy findings available npletion of cause of
lan:	ortifice ctor, p	Be C	25. Was case referred to medical examiner?					26. Plac	ce of Death	(Check			1401	100	
VII hysic	his ce Il dire	၉	1 Yes 2 No	Hospital:	patient 2 ER	/Outpatien	3 🗆 DOA	Other	: XX Nurs	sing Hon	ne 3E n esi	dence	6 Other (S	pecify)	
on of	ath. ir. After t ne funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	ation	f injury 28i , Day, Year)	b. Time of injury	28c	. Injury : work?	at	2	8d. Describe I	now inju	ury occurred		
Division of Vital tal or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	28e. Place o	f Injury - At home g, etc. (Specify)	, farm, stre	et, factory, c	office		2	8f. Location (8 City or Tov			Rural	Route Number,
e Hospit	n 24 hour ee Funera	Medical	(Check 2 ☐ Medical Ex	Physician: To the best caminer: On the basis Nurse Practioner: To	of examination an	nd/or investi	gation, in my	opinion /	n, death occu	urred at t	he time, date a	and place	ce, and due to	the cau	se(s) and manner stated
To th	vithi To th comp		29b. Signature and little of certifier	0	,	3-1-0		icense	-	F.200			Date signed (M		
			· Esperle	uples				028	3987	7		9-	13-201	1	
			30. Name and address of person &	no completed cause	of death (Item 23	a) (Type, Pr	rint)				ر حیرا	UD	2/23	9	
	Stat	e	31. Date filed (MSE Pay2'eV) 2	011 Rec	Sool 2	1	1.1	1.		U1)	- 1- /		J. J	•	
	Registra	ar	OLI NO Z	The same	m p.	Mari	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 29869 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Christine Konitzer September 18. 2011 4:00 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson <u>Gilchrist</u> Center If Under 1 Year_ If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Yea **Director** 213-14-3194 1 M 2 X F 88 Nov. 01, 1922 Baltimore, Maryland Usual Residence of Deceder 28a-f shov 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Baltimore Maryland Carney 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 2904 Fifth Avenue United States "natural", or items . Page 1 and 2 should be filed within 72 hours after death innert of Health and Mental Hygiene. Fant I fem 27 is marked other than "natural", or items luny or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Library Library Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Delia Tierney Henry Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2904 Fifth Avenue Carney, Maryland 21234 Theresa Konitzer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Morreland Mamorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State September 23, 4 Donation 5 Other (Specify) 2011 Parkville, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel & Crematice
8800 Farford Road Parkville, M

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 Interval Between Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Litter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within £2 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. **Other significant c**ond**itions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes Yes 2 A Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 - No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred ☐ Natural 5 Pending 2 Accident
3 Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month) Day, Year) 138h PATHI KUNIAR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 CHARIE BALTEMORE 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edgar L. Krotee, Sr. September 19,2011 3:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8200 Harris Avenue Parkville Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Feb. 20, 1928 Months Director 212-26-9968 83 1 😾 M 2 🗆 F Baltimore, Maryland Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 Yes 2 No Maryland Parkville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8200 Harris Avenue 21234 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iter edical Examiner Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 0 Š 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Specify: Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) m 27 is marked other than "r, et traumatic event ... Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Tool & Die Maker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Jacob Krotee Emma Margaret Lind 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trat once. Shirley Krotee (Spouse) 8200 Harris Avenue Parkville, Maryland 21234 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel—Bel Forest Hill, Maryland 4 Donation 5 Other (Specify) 19-20-201 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 21. Signature of Funeral Service License 0 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ monary Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ρ in the past 12 months? Month Year Pregnant at time of death signed by the a 2 🗌 No Unknown 9 Unknown Part II. Other significant opnditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by bullation Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page 1 Yes 2 No 2 - No Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 PNO 1 \square Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending Division 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 9-20-11 12/022 nevzon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SArto. MD 21236 KINALOZSIUMI BELAIR M 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 150 Metispa Dr. Severna Park Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Min. (Month, 1 🗆 M 2 🌌 Director 215-03-5373 99 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director MD Anne ARundel Severna Park 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21146 USA 150 Metispa Dr. items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Lee Wheeler Annie Biemiller Page 1 and 2 should be ment of Health and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 Metispa Dr; Severna Park, Maryland 21146 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Sue Brown - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final PHAGIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and I-transit death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-1 Physician/Medical Box 68760 attending philosophia IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month 4 Pregnant at time of death 9 Unknown ed by the g 9 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' certificate Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner, to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cervie 1) 1/348 tho complete ause of death (Item 23a) (Type, Print) 30. Name and address of persor ENTAMP MICHAEL

29871

3. Time of Death

10d. Inside City Limits

Approximate Interval Between

Year

1 ☐ Yes 2 🛱 No

Maryland

white

33UM

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylan		artment of I			giene Reg. 201	1 29872
			Registrar 1. Decedent's Name (First, Middle, Last)	- 001	tinoato or i	Joann	2. Date of Dea	th	3. Time of Death
	Physicia Medic		Jerome Thomas Kane				Septemb	er 3 20)ÎÎ 5:36 PM
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o		ath	4c. County of	
			Gilchrist Hospice 5. Social Security Number 6. Sex 7. Age (In yrs.	last hirthday)	Columb		lrs. 8. Date of Birtl	Howa	9. Birthplace (State or Foreign
	Funeral Director		213-01-5479 1 M 2 □ F 93	Yrs.	Months Days	Hours Mi		1917	Country) Maryland
	d d		Usual Residence of Decedent	City, Town or Lo	antinu .				10d. Inside City Limits
	anylanı a⊶f sh fied a	Director		columbia					1 ☐ Yes 2 🏖 No
	or 28,	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of W	/hat Country?
	within 72 hours after death with the Maryland glene. ier than "natural", or items 23a or 28a-f sho i; the Medical Examiner must be notified at	Funeral	1200 South East Ave.		21224			USA	
	death r item iner m		$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	I.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		- American Indian, k, White, etc.
980	s after al", o Exam	d by		46	1 ☐ Yes 2 🎇 No	Specify:		Specify:	white
2-0	hour "natur	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done	pation during most of w	vorkina I	16b. Kind of Bu	siness Industry
12	thin 72 ane. than the	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	ONOT use retired)	30///g 111001 07 11		manui	acturing
g 5	led wi Hygie other ent, ti	Be	17. Father's Name (First, Middle, Last)	1 20.	30101	18. Mother's N	Name (First, Middle,		
/lan	d be filed Mental Hyg arked oth	유	Jerome Thomas Kane			Julia	Gruber		
Man	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)				Rural Route Number		
e)	and 2 Healti tem 2:		Susan Culp – daughter 20a. Method of Disposition 20b.		33 Hemlo	ck Cone	Date Date		ty, MD 21042 City or Town, State
mo	Page 1 rent of int: If ii		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🔀 Donation 5 ☐ Other (Specify)		natory or other pla	ce)	Date		,,
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 sho Department of Health an Important: If item 27 is any injury or other trau		21. Signatur & Funer Service Livensee Rena d S Wad , Lirecto	r 22			State Ana re St; Bal		
			23a. Part 1. Enter the disease, or complications that caused the dea	ath. Do not ent					Approximate
	hysician/	77. 3	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	e Koc	v+ fai	1126			Interval Between Onset and Death
	Medical Examiner		resulting in death) a. Due to (s a consec			110			0
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consec	quence of):					_
	uted nd ransit	Examiner	cause. Enter Underiving Cause (Disease or iinjury that initiated events c						
	ate be executed hysician and the burial-transit	al E	resulting in death) Last Due to (or as a consec	quence of):					
260	cate b physis	edical	d						
(687	certifi anding use a	M/us	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fe		☐ Ectopic pregnan	CV		23d. Dat	e of delivery
Box	death the atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)	~,		Mor	nth Day Year
P.O.	hat the ed by detach		Part II. Other significant conditions contributing to death but not re	esulting in the (underlying cause g	ven in Part I.	23e. Did to	bacco use contr	ibute to the cause of death?
S,	uires t n sign ald be	Completed by	Conditioning pathy, chiopic of	JEHN.	tice pul	moron	1 🗆	Yes 2 No	3 Probably 4 Unknown
Records,	as bee 2 shou	plet	alsease atial fibriliation	\			24a. Was	osv p	Vere autopsy findings available prior to completion of cause of
Re	rsician: The law is certificate has b	Con					perfo 1 \(\sum \) Yes	rmed?	leath?
Ita	sician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 I Inpatient 2	7	LOtt	lace of Death (C		× × ×	2 11/20/08
of <	g Phy er this eral d	ie: To	27. Manner of Death 28a. Date of injury	28b. Time of	f 28c. Inju	ry at	g Home 5 Resid	ow injury occurre	111111
o	endin eath. or: Aft he fur	ficat	Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	injury	M 1	Yes 2 No			
Division of Vital	l or Att after d Direct I in by	Certificate:	4 Homicide determined 28e. Place of Injury - At I building, etc. (Special Country)		eet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. Within 54 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my kno (Check 2 Medical Examiner: On the basis of examinationly one) 3 Certifying Nurse Practioner: To the best of	wledge, death	occured at the time	e, date and place	e, and due to the ca	use(s) and manne	er as stated.
	the Fithin 24 the Formplet	Me	only one Certifying Nurse Practioner: To the best of a 29b. Signature and title of certifier	my knowledge,	death occurred at the				nner as stated. I (Month, Day, Year)
	≓ ≥ ≓ 8		Nocco Sun	CON	O A 1	1525/	·	SALM	126.47
	,		80. Name and address of person who completed cause of death (Ite	m 23a) (Type,		السرب		Thister	
			31. Date filed (Month-Day, Year) 32 Registrar's Sign	Ψ		re Ce	DICHOR	~ MD	91042
	Sta Registr		31. Date filed (Month, Day, Year) SFP 2 0 2011 33 Registrar's Sign	B. 40	ale				

	68760
LB	. Box
N KA	P.O.
LILLIA	Records,
	Vital
	of
	ivision

				_ For	Please	e Type or State o							lental Hy		gible.	00072
			_	State Registrar				Cei	rtificat	e of D	Death			Reg. NZ U	1 1	29873
		Physicia Medic	n/	1. Decedent's Name (First		T.	KALB						2. Date of De		1 Year	3. Time of Death 5:50 p M
	all some	Examin	er	4a. Facility Name (if not in STELLA M)							Location NIUM				y of Death LTIM	ORE
	and the same	Funeral		5. Social Security Number		Sex		. last birthday)	If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Bir	th	9. Birth	olace (State or Foreign
	5.	Director		213-20-46	_	1 □ M 2 🙀 F	۶	37 Yrs.	Months	Days	Hours	Min.	(Month, Da		Coun	RYLAND
		nd how at	'n	Usual Residence of Dec 10a. State 10b.	County			City, Town or Lo	cation	L			0.70.7			10d. Inside City Limits
		Maryla '8a-f s tiffied	rect	MD	N/A	A		BALTI	MORE	E						1 🌠 Yes 2 □ No
		within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	C1 2 2 2				10f. Zip		224			10g. Citizen of		
·II.		ems 2	nue	715 S. Di	EAN S	12. Was Dece	edent Ever in U	J.S. 13.	Was Dece		224 spanic Ori	igin? (Spe	cify Yes or No- Rican, etc.)		ce - Americ	
d	စ္တ	fter de , or its amine	ρ	1 Never Married 2		Armed Fo	orces? 2 X No	- 1	lf Yes, sped 1 □ Yes				Rican, etc.)	Bla Specifi	ack, White,	
:50	5-0036	ours a	eted	3 Widowed 4 [Divorced Decedent's	Year or D	ates.	16a, Dece								HITE
5	215	า 72 h :. an "na Medic	Completed		nly highest (grade completed College (1		(Give	kind of wo NOT use	rk done c	during mos	st of worki	ing	16b. Kind of		
2011		1 withii ygiene her th it, the	a)	12					SECRE	TAR					NTON	I'S
•	Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To B	17. Father's Name (First, I	Middle, Last	KALB					18. Moth			Maiden Surnar	ne)	
15	lany	should be file h and Mental F 7 is marked o traumatic eve		19a. Informant's Name/R	telationship			19b. Maili	ng Address	s (Street a	and Numb	er or Rura	al Route Numbe	er, City or Town,	State, Zip	Code)
BER	≥,	and 2 s Health em 27 ther tr		CHARLES K	10000	LEIN, ES					AVE		•	MORE, M		1224
	Jore	Page 1 anent of Hant of Hant: If ite		20a. Method of Disposition 1 🔲 Burial 2 😾 Cre	emation 3	☐ Removal from	State	Place of Dispo cemetery, crea	matory or c	ther plac			Date	20c. Location	-	
SEPTEMBER	Baltimore,	permit, Pa Departme Important any injury once,		4 ☐ Donation 5 ☐ 21. Signature of Funeral			B	AYVIEW		_				FUNER!		, MARYLAND
S	ä	permi Depar Impor any ir once.		1 /200	Sec	1	tore		700	S.	CONK	TIM	G STRE	ET, BAI	To.,	MD 21224
				23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final				ath. Do not ent	er the mod	le of dyin	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	S	h, sician/ Medical		disease or condition resulting in death)			PHAGEAL (or as a conse	quence of):	2						-	
		Examiner	<u>_</u>	Sequentially list condition	ns,	b. ———										
		ed nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	ate	Due to	(or as a cons	due De Utyl								
				that initiated events resulting in death) Last		c. Due to	(or as a conse	quence of):								
		ate be ohysici the bu	dica			d										
	98760	certific nding puse as	n/Me	IF FEMALE: 23b. Was decedent pregr	nant		tcome of preg		7					23d. E	ate of deliv	rery
B,	Вох	death ne atter ed for	Physician/Medical	in the past 12 month 1 ☐ Yes 2 🕱 No			gnant at time o	etal death 3 [of death 5 [Cther (s		СУ			N	lonth	Day Year
KALB	P.O.	at the d by the detach	Phy	9 Unknown Part II. Other significant	conditions	contributing to	death but not r	esulting in the	underlying	cause giv	ven in Part	t 1.	23e. Did t	tobacco use co	ntribute to t	he cause of death?
	S, F	uires th signe ald be	ed by										1 🗆	Yes 2 No	3 🗆 Pro	bably 4 🔀 Unknown
LILLIAN	Records,	aw requas beer 2 shou	Completed by										24a. Was		prior to co	opsy findings available ompletion of cause of
H	Rec	The la	Com										_ perfe	ormed? 2 😿 No	death?	2 🗆 No
	ita	ician: certific	Be	25. Was case referred to examiner?		Hospital:				Oth	or:		k only one)			
) t <	Phys r this eral di	e: To	1 ☐ Yes 2 🛣 No 27. Manner of Death		28a. Date	of injury	ER/Outpatie		OA 28c. Injur	4 ∐ N y at			dence 6X 01 how injury occu		HOSPICE
	on .	anding sath. ir: Afte he fun	ficat	2 Accident	Pending Investigat	tion	nth, Day, Year)	injury	М	work	Yes 2	□No				
	Division of Vital	or Atte	Certificate:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not determine	28e. Place	e of Injury - At ling, etc. (Spec	home, farm, st ify)	reet, factor	y, office			28f. Location (City or To		ber or Rura	l Route Number,
		To the Hospital or Attending Physician: The law requires that the death certificate in within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 D N	ledical Exa	hysician: To the laminer: On the baurse Practitione	sis of examinat	ion and/or inves	stigation, in	my opinio	on, death o	occurred a	t the time, date	and place, and o	lue to the ca	ause(s) and manner stated.
		To the vithin To the comp.	2	29b. Signature and title o) /	L_	, Mowooge			e number	with pit		29d. Date sign		
. (•			30. Name and address of	elea f person wh	o completed on	Se of death (Its	Ofw em 23a) (Time	Print)	RI	27	4	14	7/	16/1	/
10				JUNECIA W	HITE,	CRNP :	2300 DU	LANEY		Y RD	. T	IMONI	UM, MD	21093		
1		Stat Registra		31. Date filed (Month, Da)	P 2 0	2011	Rear's Sign		back	1						
1X	DHM	1H 17 Rev 06-2	_	<u> </u>	., ., .,	20111	CHECK !	14								

Please Type or Print in Black Indelible inko Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month () Physician/ 350 P M Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLANd TIMORE N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 🗆 F Months Days Hours Min. 85 Director 2/1925 N.C. 28a-f show 10a. State 10b. County with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d, Inside City Limits Funeral Director Baltimore MD N/A 1 🛛 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21213 1702 Darby Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. The Train and Train Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Beth. Steel Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Levi Lewis Lena Sauls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilhelmenia Richardson-401 Lynnerest Dr. Chattanooga, TN 37411 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o
once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Old Mill Cemetery 9/24/2011 Goldsboro, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H 1101 E.North Ave. Baltimore, MD 21202 21. Signature of Funeral Service Licensee 23a. Part 1. Ent. I the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 'hysician/ NEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 4 to3 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Pregnant at time of death 2 No been signed by the should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after det th.

To the Funeral Director: After this certificate has been sit combleted filled in by the funeral director, page 2 should the strain of the funeral director, page 2 should the funeral director. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv death? 1 Yes 2 No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature Name and address of person who completed cause of death (Item 23a) (Type A Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland / Depa	artment of H			70		298	75
			Registrar 1. Decedent's Name (First, Middle, Last))	Cer	tilicate of L	Jeath	2. Date of De	Reg. No.		3. Time of	
Ш	Physicia Medi		Eileen	Lally				Septemb	er 17	2011	4:15	Ам
	Examir		4a. Facility Name (if not institution, give s Stella Maris	treet and number)		4b. City, Town, or Timoniu	Location of Deat	n	4c. County Bal	of Death timor	е	
	Funeral Director		5. Social Security Number 6. Sex 030-14-4311 1 Usual Residence of Decedent	7. Age	(In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bird (Month, Da October		Countr	ace (State of y) achuse	
	ryland I-f show ied at	Director	10a. State 10b. County Maryland Baltimo:	ma	10c. City, Town or Loc Baltimore					10	d. Inside Cit	,
	the Ma or 28a e notif		10e. Street and Number	re	Daltimore	10f. Zip Code			10g. Citizen of	What Countr		2 23 NO
	h with ns 23a nust b	Funeral	6806 Bellona Ave.			21212			United	State	S	
980	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ender Armed Forces? 1 ☐ Yes 2 XI If Yes, Give Year or Dates.	No.	Vas Decedent of Hi Yes, specify Cuba	ın, Mexican, Puert		Blac	e - American ck, White, et whit	C.	
15-0	72 hou n "natu ledical	nplet	15. Decedent's Edu (Specify only highest grad		(Give I	ent's Usual Occup			16b. Kind of B	usiness/Indu	ıstry	
212	within giene. er thar the M		Elementary/Secondary (0-12)	College (1-4 or 5- 5+	F)	O NOT use retired) n ministr	y	_]	Mission	Helper	rs Sac	red Ht
Baltimore, Maryland 21215-0036	d be filed Mental Hyg arked oth	To Be	17. Father's Name (First, Middle, Last) Martin J. Lally					ne <i>(First, Middl</i> e, 1en Gaf		e)		
Mar	d 2 shou alth and 27 is m		19a. Informant's Name/Relationship (Type Sr. Martha Pavelsk		rdian 1001	g Address (Street a	and Number or Ru a Rd. 3	ral Route Numbe	r, City or Town, S		ide)	
nore,	ige 1 and nt of Hez t; If item		20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ F			natory or other plac		Date 0011	20c. Location	•		.1
altin	mit. Pa partme portan / injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Green Moun	It Cremato . Name and Addres	ory Sep.	20,2011	Baltimo	ore, M	aryıa	<u>na</u>
m	P E E		John D. Mitchel		M1 65	Name and Address tchell-W 00 York	redereid Rd. Ba	Tuneral 1timore,	MD 21	212		
lastic.	Physician/		23a. P 11. Enter the disease, or compli s ck, or heart failure. List only one Immediate Cause (Final	e cause on each line.	the death. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory an	rest,	í	Approximate nterval Betv Onset and C	veen
- gar	Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence of):							
	+	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
0	aath certificate be executed attending physician and I for use as the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of):							
8760	ificate ng phys as the	Medi	IF FEMALE:	d								
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 N No 9 Unknown	3c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	P Etal death 3	Ectopic pregnanc Other (specify)	У		I .	ite of deliver onth D	*	'ear
ds, P.O.	requires that the des been signed by the a should be detached	ed by Ph	Part II. Other significant conditions cor	stributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use cont Yes 2 No		cause of de	
Division of Vital Records,	I Physician: The law rec If this certificate has bee eral director, page 2 sho	Completed by							osy rmed?	Were autops prior to com death? 1 🔲 Yes 2	pletion of ca	
ital	sic ian: certific irector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		Othe	ace of Death (Che					
of V	ig Physical distribution	te: To	27. Manner of Death	1 ∐ Inpatie 28a. Date of injury (Month, Day,	nt 2 ER/Outpatien / 28b. Time of injury	t_3 □ DOA 28c. Injury work	4 □ Nursing F at	lome 5 Resid	dence 6 X Oth low injury occurr		HOSP1	<u>CE</u>
ion	ttendir death. tor: Afi / the fu	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2 No					
Divis	tal or A		4 Homicide determined	building, etc.	y - At home, farm, stre (Specify)	ет, тастогу, опісе		28f. Location (S City or Tow	Street and Numb n, State)	er or Hural H	loute Numb	ə <i>r</i> ,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After thi completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examino only one) 3 Certifying Nurse	er: On the basis of ex		gation, in my opinio	n, death occurred	at the time, date a	nd place, and du	e to the caus	e(s) and mar	ner stated.
	vithir Vithir Congression	_	29b. Signature and title of certifier	1.0	,,	29c. License			29d. Date signe	d (Month, Da	ay, Year)	
			* HAMOSE	W	ath /ltom 00-1 T	17/	49792		9/19	1201		
			30. Name and address of person who co		ath (Item 23a) (Type, Pi ULANEY VAL		TIMONIU	M, MD 21	.093			
	Star Registra		31. Date filed (Month, Day, Year)	32. Registrar								

SEPTEMBER 17, 2011 4:15 a.m.

EILEEN LALLY

			For State Registrar	State of M	larylan		artment of l tificate of		nd Me		giene Reg. N2 0		29876
	Physicia	an/	Decedent's Name (First, Middle		-1.6					2. Date of Dea	th	Year _	3. Time of Death
	Medic Examir	cal	Robert Bar 4a. Facility Name (if not institution	tholomew n, give street and number)	Lluf	rio	4b. City, Town, o	or Location of		septem	per 14	, 2011	11:05 AM
-			Riverview Care				Essex				Ba	ltimor	
	Funeral Director		5. Social Security Number 213–12–2181	6. Sex 1 X M 2 \square F		as <i>t birthday)</i> 89 Yrs.	If Under 1 Year Months Days			Date of Birth 037017		9. Birth Mair y	place (State or Foreign Tand
land	show d at	قِ	Usual Residence of Decedent 10a. State 10b. County Mography 2007	imore		y, Town or Lo	eation					-	10d. Inside City Limits
ie Mary	r 28a-f notifie	Funeral Director	Maryland Balt		ES	sex	10f. Zip Code				40- 04	- 6 1 M/L - 1 C - 1 .	1 ☐ Yes 2 No
with th	s 23a c iust be	eral	2308 Turkey Po	int Road			21221				10g. Citizen o		ntry ?
and 21215-0036 be filed within 72 hours after death with the Maryland	den trygener. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	è	11. Marital Status 1 □ Never Married 2 ☐ Ma 3 □ Widowed 4 □ Divorce	If Yes, Give	No 19	42-	Vas Decedent of F Yes, specify Cub	an, Mexican, I	n? (Specif Puerto Ric	y Yes or No- an, etc.)		ace - Americ lack, White,	etc.
5-00	"natura dical E	Completed	15. Decede	ent's Education sest grade completed)	,,,	16a. Deced	ent's Usual Occup		of working	Į	16b. Kind of	· W	hite dustry
2121 within 73	ar than the Me		Elementary/Seconday (0-12)	College (1-4 or 5	5+)		NOT use retired,		ii working		Cab Co	ompany	
Maryland 21215-0036 2 should be filed within 72 hours after	rand Mental Hyg 7 is marked oth raumatic event,	To Be	17. Father's Name (First, Middle, William Llufr:	,		•		18. Mother's			Maiden Surna	me)	
	or nealth and Menta f item 27 is marked cother traumatic e		19a. Informant's Name/Relations Kathleen Sobota				g Address (Street Turkey						
Baltimore, Dermit. Page 1 and	t; If item	i i	20a. Method of Disposition 1 X Burial 2 Cremation		C	emetery, crem	sition (Name of atory or other pla		Dat		20c. Location	•	
altin mit. Pe	Important; If any injury or once.	- 5	4 ☐ Donation 5 ☐ Other (Unada la la la la la la la la la la la la la	HO		ary Ceme						Maryland
n 8.2	5 5 5 5	-	23a. Part 1 Enter the disease, o	r complications that acuses	d the death							'Mār∳l	and 21221
	sician/ ledical		shock, or heart failure. List Immediate Cause (Final distance or condition resulting in death)	only one cause on each line a. Due to (or as a	910L	vasi	u lov			o Crn	·	5	Approximate Interval Between Onset and Death
Ex	aminer	¥	Sequentially for conditions, if any, leading to immediate			,							
uted	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a	a consequ	ence of):							
) oe exec	physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a	a consequ	ence of):							
8/00 tificate b	ng phys as the	Medical	F FEMALE:	d									
. BOX 08 In death certifi	To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3 🗌	Ectopic pregnand Other (specify)	ру				Date of deliv Month	ery Day Year
s that the	igned by be detad	þ	Part II. Other significant condition					ven in Part I.					he cause of death?
ords require	been s	leted	Hy B	sclerotic ertensic	- 1	Jear	ra	Oste	+	1 □ Y 24a. Was a			bably 4 Unknown psy findings available
VICAL MECOFOS, hysician: The law requires	ate has page 2	Completed								autops perfor	sy	prior to co death? 1 \(\subseteq \text{Yes}	mpletion of cause of
/ Ital sician:	certific irector,	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital:			loth	ace of Death			-		
Ing Phy	fter this	ate: To	27. Manner of Death 1 Natural 5 □ Pendir	28a. Date of injur	ry	ER/Outpatient 28b. Time of injury	28c. Injur	y at			ence 6 🗌 Otow ow injury occu		9
VISION OF Artending Principles of Artending Principles	ector A by th∈ fi	Certificate:		igation not be 28e. Place of Inju	ıry - At hoi	me, farm, stre		Yes 2 □ N				nber or Rura	Route Number,
pitallor ours afte	eral Dir filled in			building, etc						City or Towr			
the Hos	the Fun	Medical	(Check 2 Medical B	g Physician: To the best of Examiner: On the basis of ex g Nurse Practioner: To the	xamination	and/or investi	gation, in my opini	on, death occu	irred at the	time, date an	d place, and c	due to the ca	use(s) and manner stated.
To	To		29b. Signature and title of certified	1/8-	D.	0	29c. Licens	number	73	2	9d. Date sign	ned (Month,	Day, Year)
-\			30. Name and address of person	who completed cause of de	eath (Item	23a) (Type, Pr	Mace	Aue	., 6	Bakti.	nore	M	02/22/
	Stat Registra	е	31. Date filed (Month, Day, Year) SEP 2 0 2	2. Registra	ır's Signatı	ure de	4.1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		3 0	0011	29877
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death		. NG. U	
	Physicia		Matilda W. Lavery		2. Date of Death Month Sept. 1	Day 2011	3. Time of Death 7:00 A M
	Medio Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Jept. I	4c. County of Death	
			3408 Pleasant Plains Dr.	Reisterstow	wn	Baltin	
	Funeral	ĺ.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	9. Birth	place (State or Foreign
	Director		141_09_2865 1 M XXF 91 Yrs. Usual Residence of Decedent		sep. 24	,1919 Nev	Jersey
	and show	ᅙ	10a. State 10b. County 10c. City, Town or Lo	ocation		T	10d. Inside City Limits
	Mary 28a-f otifie	irec		terstown			1 ☐ Yes XXNo
	th the	a D	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Cou	
	ath wir	Funeral Director	3408 Pleasant Plains Dr. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21136	**- X/ N	U.S.A	
(0	er deg or ite		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 【 No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
<u>ළ</u>	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	XX Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2XXNo Specify:		Specify: Wi	nite
2-0	2 hou "nat u edica	plet	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of working	168	b. Kind of Business In	ndustry
7	ithin 7 ene. • than he Mi	Som	Elementary/Seconday (0-12) College (1-4 or 5+)	oo NOT use retired) Homemaker		Own Ho	om e
2	lled w I Hygi other ent, t	Be (17. Father's Name (First, Middle, Last)		(First, Middle, Maid		JiiC
lan	should be filed within 7, and Mental Hygiene. is marked other than aumatic event, the ME	To	Peter Wasung	Julia		. ′	
Maryland 21215-0036	should be filed v h and Mental Hyg 7 is marked othe traumatic event,			ing Address (Street and Number or Rural			
മ്	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Joyce Lavery Hall/ Daughter 3408		s Dr. Rei	istersto	wn,MD21136
Baltimore,	Page 1 anent of Hant of Hant of Hury or of		20a. Method of Disposition 1 ☐ Burial XXI Cremation 3 ☐ Removal from State 20b. Place of Disposition 20c. Place of Disposition 20c. Place of Disposition	osition (Name of matory or other place) aiths ry & Chapel 9/21	ate 200	c. Location - City or Ti	- 1
	permit. Page Department Important: I any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Fundamental Service (Specify)	ry & Chape 1 9/21 2. Name and Address of Facility ECK	/11	Manchest	
B	permit. Departr Imports any injt	- 1		1605 Reisterstov			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or	r respiratory arrest,		Approximate
12.	Ph_sician/		Immediate Cause (Final disease or condition				Interval Between Onset and Death
أمسد	Medical Examiner		resulting in death) Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	ted Insit	Examiner	Cause. Enter Underlying Cause Disease or in jury				
	execu an and rial-tra	Ĕ	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
O O	death certificate be executed re attending physician and ed for use as the burial-transit	dical	d				
200	artifica ding p	Me	IF FEMALE:				
ROX	attence for us	cian	23b. Was decedent pregnant in the past 12 months 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	rery Day Year
<u>n</u>	the de	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 L 9 Unknown				
7. O	that I	by P	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	co use contribute to tl	he cause of death?
ds,	quires en siç ould b	ted			1 🗆 Yes	2 ☐ NO 3 ☐ Pro	bably 4 🗆 Unknown
S S	law re nas be	Completed			24a. Was an autopsy	prior to co	psy findings available empletion of cause of
Vital Records,	t The				performed		2 🗌 No
0	sician certif irecto	m	25. Was case referred to medical examiner? 1 Yes 2 Hospital: Inneticet 3 FR/Ottastee	26. Place of Death (Check of Other:			
5	g Phy er this eral d	은 :e:	27. Manner of Death 28a. Date of injury 28b. Time of	nt 3 DOA 4 Nursing Hom f 28c. Injury at 28	ne 5 Residence 8d. Describe how in	e 6 Other (Specify niury occurred)
0	endin eath. or: Aft	licat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No			1
DIVISION OF	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, structural building, etc. (Specify)	eet, factory, office 2	8f. Location (Street City or Town, St	t and Number or Rural tate)	l Route Number,
5	pital ours a eral D	edical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	coourad at the time date and also and)	
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Medi	(Check only one) Wedical Examiner: On the basis of examination and/or investorily one) Certifying Nurse Practioner: To the best of my knowledge, or the basis of examination and/or investorily or inve	tigation, in my opinion, death occurred at t	the time, date and nla	are and due to the cal	use(s) and manner stated
	Vithi Voth		29b. Signature and title of certifier	29c. License number		Date signed (Month,	
			I just the	27123		9/19/201	\
1	101		30. Name and address of person who completed cause of death (Item 23a) (Type, F	,	Dai	en town	
	State	e	31. Date filed (Month, Day, Year) 32. Registrar's Spray	M 1 F	(4,54	Cm 40 m	m) 2113(
	Registra	_	SEP 2 0 2011 Seneral 32. Registrar's Stratus				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeth Month em ber Day Lombardi Physician/ 3:04PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore White Marsh Brightview Assisted Living 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Months Days Hours 01-04-1917 94 **Director** 216-05-0603 1 M 2 X F Yrs. Usual Residence of Decedent or 28a-f show notified at Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22 months any injury or other traumatic event, the Marie 1 and 1000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director White Marsh Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21236 Funeral 8100 Rossville Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Building Industry Switchboard Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine Livolsi Angelo Patrinicola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 285 Carlow Drive Wilmington, DE 19808 Mr. Edward J. Lomardi - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial 09-19-2011 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Pinal disease or condition resulting in death) Cuncer Bladder Physician Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 \square Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760 Division of Vital filled in by 24 hours after Funeral Direc within 24 hor To the Fune completely f

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS Rajapakst M.D. 2835 Smith AV

5203 Baltimore MD

State Registrar

Medical

31. Date filed (Month, Day, Year)

Please Type of Printing Black Indelible Ink Fraure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Terner Inge Lamm 2011 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Carroll Hospice Dove House Westminster Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** CountryGermany 1 🗆 M 2 😾 F Months Hours Min (Month, Day, Year, 215-38-5252 77 **Director** 1934 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location notified at Director MD Carrol1 Mt. Airy 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ems 23a or Funeral 7910 Bennett Branch Road 21771 USA items ? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin ģ Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Midowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) College (1-4 or 5+) food service Elementary/Seconday (0-12) professional chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlotte Wesenberg Max Terner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5222 Woodbine Rd., Woodbine, MD 21797 Mr. Bert Lamm (son) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Pine Grove Cemetery 9-21-11 Mt. Airy, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Parge Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one capen on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph. sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Tes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 24 hours after death.
Funeral Director, After this certificate has autopsy performe page 2 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Tother (Specify) | NP471(F) 2 1 No Hospital Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) WST 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signatur nd title of certifie Date signed (Month. Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flavio Kruter Alliance Hematology Oncology PA 555 South Center St. Westminster, MD 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#30perDVR, g919 9-20-11 d.o. State of Maryland / Department of Health and Mental Hygiene 1 _ For State 29880 Reg. N2 0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vear Mack September 2106 Jessie 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Merry Medical Center Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 € M 2 □ F Months Days Hours 95 Yrs Director 249-38-1689 S.C. 1916 Usual Residence of Deceden 28a-f show 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director N/A items 23a or 28a-f s er must be notified MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 2028 Mt. Royal Terrace #504 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or item I Examiner n 11. Marital Status 14. Race - American Indian, was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🙀 No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) J.H. Univ. House Keeping N/A 11thBe 18. Mother's Name (First, Middle, Maiden Symame, Corrina Gillespie 17. Father's Name (First, Middle, Last) ပ္ Arthur Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Mack-Daughter #504 Balto., MD 21217 Mt. Royal Terr. 2028 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 😰 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 9/24/2011 Baltimore, MD 4 Donation 5 Other (Specify) Trinity Cemt. 22. Name and Address of Facility March F/H 1101 E. North Signature of Funeral Service Licenses Ave. Baltimore, MD 21202 mille 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Hypoxic respiratory

Due (or as a consequence of): 1.day disease or condition Medical resulting in death) Examiner Preumonia 2 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dualto (or self-consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? é Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27, Manney of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. - Physician NP1: 1265731418 otember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chalita Atallah Mercy Ctr Balto Md 21202 32. Registrar's Signature 31. Date filed (Month, Day State

DHMH 17 Rev 7/2009

Registrar

2 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ 17 Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 1005 E. Cold Spring Lane If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗽 F Days Hours Min. 1*/*14/1928 Director 216-20-9065 83 MD Usual Residence of Decedent 28a-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 Completed by Funeral 1005 E. Cold Spring Lane USA within 72 hours after death with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Federal Tin & Elementary/Seconday (0-12) College (1-4 or 5+) N/A Paper Laborer Be permit. Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Addie Roles Harry Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6211 Golden Ring Rd. Rosedale, MD 21237 Kenneth Jones-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 9/23/2011 OwingsMills, MD Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of Immediate Cause (Final Physician/ disease or condition resulting in death) man Medical Due to (or as a consequent of) **Examiner** Sequentially list conditions, if any, eaching to in a solute cause. Enter Underlying Due to for as a consection of the been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions tributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has completed filled in by the funeral director, page 2 autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 19X Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d, Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 29882 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Estella L. Meyers 09 8:00 P M Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 8. Date of Birth (Month, Day, June 8 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Days Hours Min. 65 Yrs **Director** 212-48-6023 1946 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Funeral Director 28a-f 1 Tes 2X No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? must be items 23a 980 Chipper Drive 21040 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Black, White, etc. ö 1 Never Married 2 Married Completed by 1 🗌 Yes 2 🚉 No If Yes, Give Year or Dates 1 Yes 2X No Specify. WHITE 3 X Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) 8th grade Home Maker Own Home other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Otto Zukowski Estella Addison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Troy McCauley - SON 12710 Winchester Drive, Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 5 Other (Specify) 09-19-2011 | Baltimore, Maryland Metro_Crematory INC 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore MD 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Ph sician/ disease or condition Medical resulting in death) Examiner Severe eneumonia Sequentially list conditions, if any leading cause. Enter Underlying Examiner Dian to for as a consequence Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) signed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Serticemia or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Vunknown 24a. Was an Were autopsy findings available prior to completion of cause of has autonsy perform death? this certificate 1 Yes 2 No Yes Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 W No Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Division of 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 5 Pending 1 Tes ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier September 15, 2011 D 63420 address of person who completed cause of death (Item 23a) (Type, Print)

UPPER Chesapeake dr, Bel Air, MD 21014 30. Name and Upper Chesapeake Sid 2. Knaral, MD 31. Date filed (Month, Day, Year) . . State Registrar

DHMH 17 Rev 7/2009

mocco76658

WVER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

haron McKnight	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 20 1 2	9883
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time	of Death
}	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 504 Shoridan Avanua	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (Months Days Hours Min. 5/3/1957 Foreign Country)	State or
id how any Es.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. In MD N / A Baltimore 1.50	side City Limits Yes 2 No
ith the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 Sheridan Ave. #2 21212 USA	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", ar items 23a or 28a-fab traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No specify: White, etc. Specify: Black	an, Black,
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exam Completed		
nore, MD 21215-0036 ges I and 2 should be filed within 72 nt of Health and Mental Hygiene. t: If item 27 is marked other than inther traumatic event, the Medical To Be Comple	Harold Smith Eva Beasly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State Zin Coo	de)
re, MD 1 and 2 sho F Health and If item 27 is or traumati	Relly Sanders -Daughter 1245 Linworth Ave. Apt. 2A Balto., MI 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, Series 2 Average 20c. Location - City or Town, Series 20c. Location	21239 tate
Baltimore, MD 21215-C pernit, Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury ar other traumatic event, the 1 To Be Co	4 Donation 5 Other Specify: Greenmount Cemetery 9/15/201 Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. No.	
Physician /Medical =xaminer		eximate Interval
	Due to (or as a consequence of): Sequentially list conditions b.	L
ted nisit Examiner	cause : Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
O, e be execute ysician and burial - trar	x UNPENDED 23a,pt.II,27 per me g920 10-5-11 vt	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directur: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Es	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year
i, P.O. I res that the signed by the detached by by by by by by by by by by by by by	Diabetes Mellitus Chronic Obstructive Pulmonary 1 Yes 2 No 3 Probably 4	
tal Records, sian: The law require. certificate has been signetor, page 2 should be Be Completed	Disease 24a. Was an autopsy fin prior to completion death? 1 ✓ Yes 2 No 1 ✓ Yes	
F Vital Rec Physician: The r this certificate al director, page To Be Con	25. Was case referred to medical examiner? 1 Yes 2 No No No No No No No No	
sion of Attending Potents. After the funera y the funera cation: 3	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending 2 Accident Investigation	
Division o To the Rospital or Attending within 24 hours after death. To the Faueral Directur: Afte completely filled in by the fune fedical Certification:		Number, City
To the Ho within 24 P. The the Fun completely	(Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(and manner stated.	
	O.C.M.E. September 14, 2011 30. Name and address of person who completed cause of death (Item 23a)	
<i>/</i>	Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <u>Elizabeth B. Muse</u> 7:29 Sept 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. 223-32-6787 **Director** 82 1 🗆 M 2 🗶 F Oct. 4 1928 VA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😿 No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Rd. SSG333 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 7:49 а.ш. Armed Forces Black, White, etc. Mental Hygiene. narked other than "natural", or i þ 1 Never Married 2 XMarried 1 ☐ Yes If Yes, Give 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>rtist - Muse</u> Studios is marked other 2011 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ephraim C. Buck, Jr. Charlotte Nell Morrison Buck 15, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Muse/daughter 10340 Swift Stream Place, Apt. 413, Columbia 1 and 2 s of Health item 27 MD SEPTEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 9/17/11 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD Dulaney Valley Memorial Gardens 21. Signature of Fun R. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
D. W. Padonia Rd., Timonium, MD 21093 Mionael a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ALZHEIMERS DISEASE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Dav Year 1 Yes 2 Unknowr been signed by the sahould be detached 9 Unknown ELIZABETH MUSE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law has ye 2 autopsy page performe Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No 2 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After d in by the funer 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Cartifying Nurse Practition or 16 the best of my investigation and occurred at the time, date and place, and due to the cause(s) and manner stated X Cartifying Nurse Practition or 16 the best of my investigation and occurred at the time, date and place, and due to the cause(s) and manner at elabed. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State SEP 2 0 2011 Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 29885 For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 56 FM NO 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner TIMOTE 550013 Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month Day Year 15, 1927 1**X** M 2 □ F Months Days Hours Min. 217-20-3938 84 Yrs Director Usual Residence of Deceden 10b. County 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ☐ Yes 2 ☐ No notified **Baltimore Baltimore City** MD 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral U.S.A. 21215 3139 Sequoia Avenue death v items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 Yes 2 No Black If Yes, Give Year or Dates 7/19/1947 Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work serviced)
life, DO NOT use retired)
Skilled Worker (Give kind of work done during most of working Elementary/Seconday (0-12) College (1-4 or 5+) **Bethlehem Steel** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Alice Moorman **Henry Moorman** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1810 Dukeland Street Baltimore, MD 21216 19a. Informant's Name/Relationship (Type, Print) Lydia Lee 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Garrison Forest Veterans Sep 08, 2011 Owings Mills, Md. 4 Donation 5 Other (Specify) S f Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition 40011 Medical resulting in death) Due to (or as a consequent Examiner Sequentially list conditions, # any, leading to firm adiate Examine cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached fo Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes plnous 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performe 2 🗆 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certil 29c. License numbe 29d. Date signed (Month, Day, Year) ame a ess of person who com leted cause of death (Item 23a) (Type, Print) 2000 W. 10 32. Regis

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2011 Year Walter D. MacEwen, Jr. Sep. 8:30 P M 18 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Hospice If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth Hours Min (Month, Day, Year) 215-05-8042 99 XXM2 F Nov.12,1911 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Owings Mills Baltimore 10e. Street and Numbe 10g. Citizen of What Country? U.S.A. 21117 12341 Greenspring Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes XX No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates Specify: White XXWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Meat Processing Industrial Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Mildred Eppley Walter D. MacEwen, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12341 Greenspring Ave. Owings Mills, MD 21117 Alan MacEwen / 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other 9/24/11 Owings Mills, MD Carroll's Cemetery 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of E

Physician/ Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

ည

Examiner

Funeral

Director

shov or 28a-f shov notified at

ò

"natural", or items 23a or edical Examiner must be

permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical ince.

with the Maryland

72 hours after death

Baltimore, Maryland 21215-0036

September 18,

attending physician and for use as the burial-transi • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis ed by the a signed by I should To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2

Division of Vital Records, P.O. Box 68760

Walter Macewen

	Tuesto	/mm 1160	05 Reistersto	wn Rd. Owir	ngs Mills, MD2111
	23a. Part 1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not enter the one cause on each line. a. CONGESTIVE HEART FA Due to (or as a consequence of):		or respiratory arrest,	Approximate Interval Between Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.			
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		opic pregnancy er (specify)	2	3d. Date of delivery Month Day Year
npleted by Pr	Part II. Other significant conditions co	ontributing to death but not resulting in the underl	ying cause given in Part I.	1 Yes 2	No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of
5				performed? 1 ☐ Yes 2 X No	death? 1 🗌 Yes 2 🗍 No
Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death (Chec	k only one)	
٥	1 L Yes 2 X No	1 Inpatient 2 ER/Outpatient 3		ome 5 Residence 6	X Other (Specify) HOSPICE
Certificate:	27. Manner of Death 1		work?	28d. Describe how injury	occurred
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
Medical	(Check 2 Medical Exami	sician: To the best of my knowledge, death occur iner: On the basis of examination and/or investigations se Practitioner: To the best of my knowledge, deat	on, in my opinion, death occurred a	t the time, date and place,	and due to the cause(s) and manner stated.
-	29b. Signature and litle of certifier	- 4	29c. License number	29d. Date	signed (Month, Day, Year)

State

Registrar

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP

31. Date filed (Month, Day, Year)

SEP 2 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day September 091.20 **Physician** ames 14 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Days Months Hours 1**X** M 2□F Maryland 60 214-56-7927 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 2 X No Director Dunda1k MD Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number United States 21222 3000 Dunglow Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc Tyes 2 [If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: <u>م</u> White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical College (1-4 or 5+) Elementary/Secondary (0-12) Computers 2 Years Computer Programmer 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Louise Chell Joseph P. Marsheck ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Ellen M. Marsheck (Wife) 3000 Dunglow Road Dundalk, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from Hilltop Service Corp. 9/20/2011 Towson, Maryland 5 Other (Specify) 4 Donation 21. Signature Funeral Service Line see 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on such line. shock, or heart failure. List only one cause on Immediate Cause (Final **Physician** minute disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Myocard The law requires that the death certificate be executed nding physician and use as the burial-trar Box 68760, Physician/Medical attending p IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy Year Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No ed by the a Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò director, page 2 should be 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an renormed' 2 No 2 N 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗡 Inpatient 2 ER/Outpatient 3 DOA ၉ s after death.

I Director: After this c filled in by the funeral 27. Man or of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural Injury 5 Pending investigation 1 Tes 2 No М 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: within 24 hours a To the Funeral D Hospital

State Registrar

Medical

29a. Certifier

(check only one)

29b. Signature and title of certifier

31. Date filed (Mor



4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

September 14,2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RE9-000

11-06894 Guy Marcum Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	c or iviaryiana	Certific			i i i i i i i i i i i i i i i i i i i	19910	Reg.	. No.		29888
Physiciar Medical Examin	1/	Decedent's Name (First, Middle,L	ast) Guy	=	Marcu	.m			te of Death	Day Y	'ear	3. Time of Death 1322 hrs
40-	ı	4a. Facility Name (if not institution, o	give street and number	r)	4b.	City, Town, o	or Location of Dea		Jernber -		ty of Death	
Funeral		Johns Hopkins Bayview 5. Social Security Number 6.		ge (In yrs. last bir		Baltimore If Under 1 Ye	ear If Under 24H	Irs. 8. D	ate of Birth	(MM/DD/YY	YY) 9. Bir	N/A hplace (State or
Director		218-26-6334		31		Months Da		_	ay 4,		Const.	
any	F	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	اة	MD Ba	ltimore				Dunc	lalk				1 Yes 2 No
r 28a-f	Director	10e. Street and Number	D - 1		1	Of. Zip Code	01.000		10g	. Citizen of \		•
with the se 23a o	힐	3142 Cornwall 11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. Was D	ecedent of H	21:222 lispanic Origin? (Specify Y	es or No-	Unite		ates can Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f should up or other traumatic event, the Medical Examiner, must be notified at once.	Funeral	1 Never Married 2 Marrie 3 Widowed 4 Divorce	ed Armed Forces 1 X Yes 2 ed If Yes, Give Year K C	2 No		specify Cuba	an, Mexican, Puer	to Rican,	etc.)		nite, etc.	White
ours after	<u>8</u>	15. Decedent's Education (Specify	or Dates:	mpleted) 16a.	Decedent's	Usual Occup	ation (Give kind o		ne 1	6b. Kind of I		ndustry
36 in 72 ho han "n	Completed	Elementary/Secondary (0-12) 12 Years	College (1-4 or	5+)	Machi		e. DO NOT use re	etirea)		Stee	1 Tn/	lustry
5-00; ed with lygiene other t	통 3	17. Father's Name (First, Middle, La	st)		raciii	.III.S C	18.Mother's Nan	ne (First,	Middle, Ma			lustry
21215-0036 Judd be filed within 7 IMental Hygiene Imarked other than ic event, the Medica	9	Howard Curtis 19a. Informant's Name/Relationship		allter I 19	n Mailing Δ	ddraee (Cir				untsf		Zin Codo)
AD 2 2 shoul h and N 27 is n	<u>•</u>	Mrs. Lisa D. B1		_			Street					Zip Code)
Baltimore, MD seemil. Pages I and 2 sho Permil. Pages I and 2 sho Peparath and Peparath and Peparath and Peparath and Peparath and Peparath I alway or other traumati	Ī	20a. Method of Disposition 1 X Burial 2 Cremation	Removal from S	tate cremat	ory or other		"	Date	1	20c. Location	•	
timent ortant:	-	4 Donation 5 Other Speci		Arling			11 Cen. 1				ngtor	
Department of the position of		21. Sidiature of Pullerial Service Ele	3560			a-Ruck	ss of Facility Luneral			Dunda aryla		Inc. 21222
Physician /Medical		23a. Part I. Enter the disease, or cor failure. List only one cause on		d the death. Do no								Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic		lar Disea	se						Death
	ي	sequentially list conditions,	b. Due to (or as a cons	and the second of the second o								
	Examine	(Disease or injury that initiated	С									
uted nd ransit		events resulting in death) Last	Due to (or as a cons d.	sequence of):								
tO, e be executed ysician and burial - transit	Medical	UNPENDED	AMENDED									
8760, tificate be ng physici as the buri	- 10	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregnancy 2	Fetal	death 3	Ectopic pregr	nancy		23d, Date Month		ay Year
Box 687 death certific	Physician	1 Yes 2 No 9 Unknow		t time of death		(Specify)						
that the d		Part II. Other significant conditions		th but not resulting	g in the und	erlying cause	given in Part I.	23	Be. Did toba	cco use con	tribute to 1	he cause of death?
Division of Vital Records, P.O. Lat or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by the finneral director, page 2 should be deated the finneral directory.	ed by			_								ably 4 Vunknown
cords, law requir has been s	сошрівтва							. 2	la. Was an autopsy performe			opsy findings available ompletion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical				26.Plac	e of Death (Check		✓Yes 2 e)	No	1 Ye	s 2 No
Vital I hysician: hysician: this certifi	0 00	examiner? 1 ✓ Yes 2 No		ent 2 🗹 ER/O				ing Home		esidence 6		
on of National Ph. It.		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Day,	ury Year) 28b. ⁻	Time of Injui	· I _	ury at Work? Yes 2 No	28d. D	escribe hov	v injury occu	rred	
ViSiOF or Attend ther death. Sirector: in by the	Ceruncation:	2 Accident Investiga 3 Suicide 6 Could no	ation 28e Place of I	njury - At home, fa	ırm, street, f						ber or Rur	al Route Number, City
E 8 5 E		4 Homicide determin	ed (Specify)						Town, Stat			
To the Hos within 24 h To the Fur completely	Ġ.	(Check only Certifying Physic	cian: To the best of n er:On the basis of exa and manner stated	amination and/or in								
To with	Ē	29b. Signature and title of certifier	and mariner stated	M			se number					th, Day, Year)
	-	30. Name and address of person who	arsellet			0.0	.M.E.			Septembe	∍r 14, 20)11
)t1			Assistant Medica	,	900 W. E	Baltimore \$	Street, Baltim	ore, Mi	21223			
Stat Registra		31. Date filed (Month, Day, Year) SEP 2 0 2	32 Registra	ar's Signatur	back	1						
- Logioti	_	DLT & U.L.	UII KENER	~ /4. /	7							

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 29889 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William Α. Orlick Sept. 2011 4:22pm ^M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Oak Grove Drive Mid<u>dle River</u> Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 219-28-2198 1 🗀 M 2 🗆 F Months Hours 78 **Director** 17,1932 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director MD Baltimore Middle River 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or Completed by Funeral 1 Oak Grove Drive 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc Armed Forces? 1 Never Married 2 Married 1

Yes 2 □ No
If Yes, Give 1 Yes 2 No Specify: Specify: White 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Bonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Container Company Supervisor 12th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stephen B. Orlick Ethel Hammen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Teresa Sechrist/daughter 112 Mace Avenue Baltimore MD 21221 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗌 Burial 2 🔀 Cremation 3 🔲 Removal from State Bayview Crematory 9/19/11 4 ☐ Donation 5 ☐ Other (Special Signature of Fundral Service Lie Baltimore MD 5 ☐ Other (Specify) 22. Name and Address of Facility 300 MAce Ave.Balto. <u>Connelly Funeral Home of Essex</u> 21221 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ In the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown g Unknown Part IJ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate funeral director, pag Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 28c. Injury at work? _1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certific 29d. Date signed (Month, Day, Year) 2011

State Registrar

27

7

0

105

Osedale, MO 21237

pleted cause of death (Item 23a) (Type Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29890 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1997 0:50PM Jeannette Prudhoe 2017 Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death 4c. County of Death **Examiner** seclate achimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) curity Number 6. Sex Age (In vrs. last birthday 8. Date of Birth (Month, Day, Ye Aug. 22 **Funeral** Months Days 1 🗆 M 2 🔀 F Hours 212-26-0740 Director 81 1940 Aug. Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MD 28a-f Baltimore 1 Yes 2 XNo Essex 10f. Zip Code 10g. Citizen of What Country? ö 23a Completed by Funeral 1000 Franklin Avenue 21221 Usa or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married Yes 2 No Trudhoe Stannette Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than ' International Elementary/Seconday (0-12) College (1-4 or 5+) Salesman 12th Paper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Calvin F. Weitzel Ethel P. Via Department of Health and M Important: If item 27 is mai any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Prudhoe /son Page 1 and 2 2254 September Drive Gambrills MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Baltimore MD Oak Lawn Cemetery 9/21/11 4 ☐ Dopation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Solvice Ligenses 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mall ancer disease or condition resulting in death) Medical Dae to (or as a consequence of): Examiner Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit unary Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown 1 ☐ Yes ≥ ₹ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires t 24 hours after death. Funeral Director, After this certificate has been sign Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy perform death?
1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 🗹 Natural 5 Pending Investigation Accident completed filled in by the Suiciden 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of per

Dr. Kamtykm

9000 Franklin Square Drive, Baltimore MD. 21237

son who completed cause of death (Item 23a) (Type, Print)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 16,2011 4:45A Carolyn Julia Palmerino Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 1506 Cherokee Lane BelAir Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Hours 1-31-1945 Maryland **Director** 212-42-5420 66 Usual Residence of Decedent "natura", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Harford BelAir 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1506 Cherokee Lane 21015 Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc δ 1 Never Married 2 X Married 2 **X**No If Yes, Give 1 ☐ Yes 2 XNo Specify: White Completed 3 Divorced 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry should be filed within 72 n. th and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sales Rep. H & S Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elizabeth Ciderio Carol Fabula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Spouse 1506 Cherokee Lane BelAir, Md. 21015 Charles Palmerino 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 9-20-2011 Highview Fallston, Md. of Funeral Service License 22. Name and Address of Facility 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 610 W. MacPhailRd. BelAir, Md. 21014 23a. Par 1. Entir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) and -transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by & RAVIS the Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 🗆 Yes 2 📉 🗖 မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury s after death.

Director, Aff 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical ocertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one onature a

Sta

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Registrar

30. Name and address of person who co

A. DICKE

JAMPI

SEP 2 0 2011

WISHINETON RD

pleted cause of death (Item 23a) (Type, Print)

826

32. Regis rar's Signature

19,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 1 2 9 8 9 2													
	Physicis	m/	1. Decedent's Name (First, Middle, Last)	2.	Reg. No. 2. Date of Death 3. Time of Death								
	Physicia Medio	cal	Georgette Pettit			Septem			ber 16, 2011 6:50 A.M				
	Examir	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death			4c. County of Dear						
Sylvade E	Funeral		Suburban Hospital 5. Social Security Number 6. Sex 7. Age (in yrs	Bethesda If Under 1 Year If Under		Date of Birth	Montgomery th 9. Birthplace (State or Foreign						
	Director		147-20-2201 1 □ M 2 🖾 F 88		Months Days Hours	Min. At	Month Day Your 1	1923 Ne	untry) W Jersey				
	d tow	1	Usual Residence of Decedent 10a, State 10b, County 10c C	City, Town or Lo	-41								
	arylan a-f sh fied a	Director	Maryland Montgomery	Dity, Town or Lot	Bethesda				10d. Inside City Limits 1 ☐ Yes 2 🔀 No				
	the Mi or 28 e noti		10e. Street and Number	10f. Zip Code			g. Citizen of What Co						
	with t	Funeral	4977 Battery Lane #1-511	977 Battery Lane #1-511				United States					
	death item		11. Marital Status 12. Was Decedent Ever in L Armed Forces?	Armed Forces? If Yes, specify Cuban, Mexican				Specify Yes or No- rto Rican, etc.) 14. Race - American Inc Black, White, etc.					
36	after al", or xamil	d by	1 □ Never Married 2 □ Married 1 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No Specify:				11, 0.0.1,		White				
9	hours natura lical E	Completed by	15. Decedent's Education 16a Decedent's Lisual Occupation					16b. Kind of Business Industry					
218	in 72 e. han "i	ᇤ	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I life. De	kind of work done during mo D NOT use retired)	ost of working		Computer					
121	d with hygien ther ti nt, the	Be C	5+	Syste	em Analyst			Engineeri	ng				
Maryland 21215-0036	be file	To E	17. Father's Name (First, Middle, Last) George Winchester			ther's Name <i>(Fir.</i> I ne Come		iden Surname)					
ary	nould nd Me s marl		19a. Informant's Name/Relationship (Type, Print)	19h Mailin	g Address (Street and Numl			ity or Town State Zi	a Cadel				
Ž	d 2 st alth a n 27 is er tra		Jeanne Ferris / Daughter		Battery Lane								
ore	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. 1 □ Burial 2 ☒ Cremation 3 □ Removal from State Mc	Place of Dispo	sition (Name of patory or other place)	Sept.	17	Oc. Location - City or	Town, State				
Baltimore,	t. Pag tment rtant: ijury o		4 Donation 5 Other (Specify)		untory or other place) Y um, Inc.	2011	B	Bethesda,					
Bal	permit. Page 1 a Department of H Important: If ite any injury or ot once.		21. Signal, re of vin rg). Servir et rensee M0161	9 75	Name and Address of Faci bert A. Pumphrey 57 Wisconsin	y Funeral Avenue	Home /B	Bethesda-Che sda, Marv	evy Chase, Inc.				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Acute Resp		Failure				Onset and Death				
	Examiner		Due to (or as a conser Sepsis	quence of):									
		ner	Sequentially list conditions, b.	quence oij,									
	uted	ami	cause. Enter Underlying Cause (Disease or linjury that infliated events c										
	ate be executed ohysician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consec										
200	death certificate be executed ne attending physician and ed for use as the burial-transi	edica	d										
687	eath certifical attending ph I for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregr	nancy			7	22d Date of de	livon				
P.O. Box	feath e atter		in the past 12 months? 1 ☐ Live Birth 2 ☐ Fe			Month Month	23d. Date of delivery Month Day Year						
0	that the des		g Unknown g Unknown										
ν. σ.	es tha signec	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Hypertension 1 Yes 2 No 3 Probably 4 Value										
ğ	requii been shoulc	lete	Acute Renal Failure 24a. Was an 24b. Were autopsy findings availa										
Ö	ne law e has age 2	Completed by	Acute Kenai Pallule				24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of				
a	sician: The la certificate ha irector, page 2	Be C	25. Was case referred to medical examiner?		26. Place of De	ath (Check only	1 Yes 2 one)	XINo 1 □ Yes	s 2 □ No				
=	hysic his ce il direc	일	1 ☐ Yes 2 🛣 No Hospital: 1 🛣 Inpatient 2 ☐	ER/Outpatien	3 DOA Other: 4 N	Nursing Home	5 Residenc	ce 6 Other (Spec	ify)				
5	ding P	Certificate:	27. Manner of Death 1	28b. Time of injury	28c. Injury at work?		Describe how	injury occurred					
SIOI	death ctor: y the	liti I	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At h	nome farm stre	M 1 Yes 2		continu /Ctur	at and Number on Du	m / Doubs Mumber				
Division of Vital Records,	al or / s after il Dire		4 Homicide determined 286. Place of Injury - AT P building, etc. (Speci.		8f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or Attending Physician: The law requires that the with Part Ahours after death. With the Funeral Director After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detach.	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. **To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	o the vithin of the comple	ž	only one) 3 Certifying Nurse Practioner; To the best of n 29b. Signature and title ovcertifier	ny knowledge, d	eath occurred at the time, dat 29c. License number	te and place, and	d due to the car	use(s) and manner as . Date signed (Month	stated.				
NOGENOUS DOGSHUS							September 16, 2011						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							, 2011				
	Jesus David Guevara-Nieto, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 2081												
	Stat Registra	and a continue of the continue											
			41 '										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPT. **HELENA** 14^{ay}, 201^y1^{ar} 3:30 pM POPINA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 408 S. COLLINGTON AVENUE BALTIMORE N/A 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days APR. 29 1 🗆 M 2 🗶 F Months Hours ÜKRAINE 218-30-4952 **Director** 90 192 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD 1X Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 408 S. COLLINGTON AVENUE 21231 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Hygiene. Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE n and Mental Hygier DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ or other traumatic e JOSEPH FELUK KATHERINE KLYBUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNA COLEMAN/ DAUGHTER P.O. BOX 45, MT. VICTORIA, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If is any injury or c 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State ST. MICHAEL'S UKRAINIAN 9/17/11 BALTIMORE, MD Donation 5 Donation 5 Donation 5 Donation Donation 5 Donation Dona 21. Signature of Fundamental Science 22 Name and Address of Facility R INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease (oronam ortery disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ng physician as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No for Day Pregnant at time of death Month Year signed by the a 1 Yes 2 19 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No the 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Certificate: s after death. completed filled in by 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 7 29b. Signature and title of certified September 16, 70:1 D0065249 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MT 21702 Robert Davidson 301 St Paul Flace Tile BUY 31. Date filed (Month, Day, Year) State Registrar **ORIGINAL**

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10c Per FH G919 9/20/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar 29894 Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18 2011 Ne 5:00 A.M Michae Sept. Joseph Medical 4a. Facility Name if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Hours **Director** 213-66-8621 1 🕅 M 2 🗆 F 56 Yrs Usual Residence of Deceden July 24, 1955 Baltimore, MD 28a-f show 10a. State with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No White Hall Twig Court MD Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21161 3 Twig Court within 72 hours after death 5:00 a.m. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 No Specify Specify: white Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Chief Petty Officer US Navy 12 2011 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary A. Kanauff Joseph Nelson Michael Rinehart, Jr. injury or other traumatic 16, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. <u>Pamel A. Rinehart - wife</u> 3 Twig Ct., White Hall, MD 21161 SEPTEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Forest Hill, MD Evans Funeral Chapel —BelAir 9//9 /11 22. Name and Address of Facility 2325 York Rd., Timonium, MD 21093 Peaceful Alternatives Funeral & Cremation Center, P.A. 21. Signature of Funeral Service auro . Part 1. Enter the disea shock, or heart failure. se, or complications that caused the List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause Final Onset and Death Ph_sician/ disease or condities LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) JOSEPH RINEHART in the past 12 months?
1 Yes 2 No Month Day Year been signed by the a should be detached 1 Yes 2 L 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 1 🗌 Yes Yes Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 👿 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNECIA WHITE, 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 2. Registrar's Sig State SED 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29895 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 17,2011 3=33 PM BERYL WAYNE RIVERS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD CO BEL AIR 5. Social Security Number 8. Date of Birth (Month, Day, MAR. 9 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 X M 2 🗆 F Days Min. Months Hours **Director** Yrs 111-40-3853 1949 NEW YORK Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MARYLAND HARFORD CO ABERDEEN 10e, Street and Number ō 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 349 WALKER STREET 21001 S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XXves 2 No
If Yes, Give
Year or Dates. Black, White, etc "natural", or 1 Never Married 2XXMarried þ 1 ☐ Yes 2X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. ARMY 12yrs lyr SOLDIER is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JOSEPH N. RIVERS JANET E. LABOUNTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Erika M. K. Rivers/Wife <u>349 Walker St.,</u> Aberdeen, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 09-27-11 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Licensee Name and Address of Facility
ILLIAM C BROWN COMI
21 S. PHILA. BLVD, COMM FUNERAL HOME-HARFORD, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ Staphlococca disease or condition sacus Medical resulting in death) Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last death certificate be executed and the burial-trar Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SOMO 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 2 🗌 No 2 1 Yes Yes Hospital or Attending Physician; Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 100 Certificate: To Other: 1 Propatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify this Division of the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

Of the Funeral Director: After 1 Natúral 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certl, ing Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier All Man 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOM SOL

DHMH 17 Rev 7/2009

Registrar

31. Date filed (M

SEP 20

Rei

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N2 0 29896										29896						
Physician			1. Decedent's Name (First, Middle, La	\ \triangle \(\triangle \)	C						2. Date of De Month	eath D	lav Y	ear	3. Time of Death	
Medical Examiner			Christopher Alles Ryan 4a. Facility Name (if not institution, give street and number) 911 Kerwin Road					4b. City, Town, or Location of Death Silver Spring					14, 2011 7:35 P M 40 County of Death Montgomery			
	Funeral Director	Director 212-90-9910 13€XM 2 □ F 50 Yrs.				If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.)	
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	rector	Usual Residence of Decedent 10a. State 10b. County MD Mont gome	ry		y, Town or Loc ver Sp								1	0d. Inside City Limits 1 ☐ Yes 2 1 No	
		Funeral Director	10e. Street and Number 911 Kerwin Rd.				10f. Zip 209					10g. C	citizen of Wha	at Coun	utry?	
		ted by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4★\(\)Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 \(\)Divorced 17. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 \(\)Divorced 18. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 \(\)Divorced 18. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 \(\)Divorced 18. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 \(\)Divorced 18. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 \(\)Divorced 18. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 \(\)Divorced 18. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 \(\)Divorced 18. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 \(\)Divorced 18. Was Decedent Ever in U.S. Armed Forces?				Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:						14. Race - American Indian, Black, White, etc. Specify: White			
		S Completed by	(Specify only highest grade completed) (Give ki				and of work done during most of working NOT use retired)						Sb. Kind of Business Industry S Postal Service			
		To Be	17. Father's Name (First, Middle, Last) Robert L. Ryan 18. Mother's Name (First, Middle, Maiden Surname) Wendy L. Lyman													
, Mar			19a. Informant's Name/Relationship (7 Colleen A. Lopez,	^{Type, Print)} daughter		19b. Mailin	g Address Steed	(Street ar	Rans	or Rural I	Route Numbe	r, City o 38	r Town, State	e, Zip C	Code)	
timore	permit. Page 1 and 2 si Department of Health a Important; If item 27 i any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State		lace of Dispos emetery, crem sapeak				Da 9/20/			ocation - Cit	-		
Bal	permit Depar Impor any in		21. Signature of F Jervice Licens		М	.015 9 22.	Name and	Address	of Facility	Rapp Silve	Funer r Spri	al ng,	& Crem	ati	on Svcs.	
-	h sician/	5 1	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Pancreatic Cancer Approximate Interval Between Onset and Death													
	Medical Examiner	e.	resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.													
	s tha gned	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Choease of inition) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):													
200		edical		d									<u>.</u>	_		_
. Box 687			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ectopic pregnancy Other (specify)						23d. Date o Month		ry Day Year				
ls, P.O.		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									t tobacco use contribute to the cause of death? Yes 2★★No 3 □ Probably 4 □ Unknown				
Records,		Completed									24a. Was a autop perform 1 Yes	sy rmed?	prior deat	to con	sy findings available apletion of cause of	_
ā.	cian: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:					e of Death	(Check o						
ر ا	y Physicar this ceral dire	e: 10	1 ☐ Yes 2 ☒No 27. Manner of Death	1 Inpatie		ER/Outpatient 28b. Time of		Other: c. Injury a	4 ∟ Nurs		5 🖾 Resid			pecify)		_
Division of Vital	to the nospina of Attending within 24 hours after cleath. To the Funeral Director, After completed filled in by the funer	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year) injury M			work? M 1 ☐ Yes 2 ☐ No			28d. Describe how injury occurred						
O .			4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 29a. Certifier 1₺ Certifying Physician: To the best of my knowledge, death occurred at the time, date an						ata and ni	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									d.				
			29b. Signature and title of certifier		29c. License number D37142				19	29d. Date signed (Month, Day, Year) 9/16/2011						
			30. Name and address of person who c Geoffrey Coleman,	ompleted cause of de MD; 1355	Picc	23a) (Type Pri	· Roc	kvi1	le, 1	MD 20	850					
	State Registra	٠	SI. Date filed (Month, Day, Year)	32. Regigra	r's Siglatu	lie Man										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 18 Physician/ 2011 Maureen September 7:15 PM M Elizabeth Medical Ruppersberger 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 161 Bladen Road Baltimore Fssex
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 1/29/1959 Birthplace (State or Foreign Country)
 New York 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F Days Hours Min. Months Director Yrs 140-58-6637 52 Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 161 Bladen Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married þ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: 3 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic injury or other traumatic Tom Lavelle Betty Mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) Scott William Ruppersberger 161 Bladen Road Essex, Maryland 21221 20a. Method of Disposition 20h Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/23/2011 Crematory Inc Baltimore, Maryland 21. Signatu re of Funeral Service Licensee ^{22. Name and Address of Facility} Bruzdzinski Funeral Home 1407 Old Eastern Avenue 9 Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Pancreatic months disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -trar Due to (or as a consequence of) resulting in death) Last ending physician are as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 X No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Dav Year signed by the ald Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available has page 2 s autopsy prior to completion of cause of death? certificate 1 Yes 2 No 2 X No Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending 1 Yes 2 No after death filled in by the Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Mr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Red 10249M 16 tembe Medical Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Pital ttos Irono Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M M 2 □ F Months Days Min. 60 Hours (Month, Day Year) Aug 15, 526-84-7353 Colorado Director 1951 Usual Residence of Decedent 10a, State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 ☑ No MD Baltimore Baldwin 10e. Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 239 3 Striminic Ct. 21013 United States items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner ò þ 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 'natural", Completed 3 Widowed 4 Divorced Specify White Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Construction Heavy Equipment Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ಲ pe 1 Roy Charles Reed Patterson permit. Page 1 and 2 should be Det artment of Health and Ment Important: If item 27 is market any injury or other traumatic e once. Develva traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jodi Reed /Wife 3 Striminic Ct. Baldwin, MD 21013 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sep 19 cemetery, crematory or other place Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Nar@rentattrison Family Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death eren Trated Ph sician/ disease or condition resulting in death) Medical Examiner Obstruction Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last physician a the burial-t Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an has autopsy page performed' certificate Yes 3 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No Other: ᅌ Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify, 27. Mann of Death Certificate: 28a. Date of injury 28c. Injury at 28b. Time of After 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural s after death. 1 Yes Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 **To the I** 29b. Signature and title o

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person

(Month, Day,

600

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29899 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{ay} 2011 John George Roemer September 11 7:00 a. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing Home Talbot Denton 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 | F 91 Ju**He^{nt}28°, 192**0 Mary land Director 219-07-8161 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Talbot Easton Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21601 USA 29814 Dustin Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married þ Yes 2 No Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Year or Dates. WII Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Ship Yard Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important; If item 27 is marked of
any injury or other traumatic eve Marie Krone John Roemer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29814 Dustin Avenue Easton Maryland 21601 Helen s. Roemer/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 9/17/11 Baltimore Maryland 21. Signature Funeral Service Licensee Theonard J. Ruck^{illy}Inc. 5305 Harford Road Baltimore Maryland 21601 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law equires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 🗌 Unknown s t een signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

Withe Funeral Director: After this certificate has it completed filled in by the funeral director, page . s autopsy performed Yes 2 2 🗌 No 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27, Mannes of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 \square No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Date filed (Month, Day egistrar's Signatu State

Registrar

11-06888	
Rianca Sullivan	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Bianca Sullivan	1- For State	State of Maryland	l / Departme Certifica			d Mental H		Reg. No. 20	11 2	9900
Physician/ Medical Examine			enata		Sull:	ivan	2. Date of Dea		3. Time o	
	4a. Facility Name (if not institu St. Agnes Hospital	tion, give street and numbe	r)	41	D. City, Town, or the Baltimore			4c. County	of Death	
Funeral Director	5. Social Security Number 216-08-1660	6. Sex 7. A	ge (In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24Hi Hours Mi	2	irth(MM/DD/YYY	Y) 9. Birthplace (St Foreign Country)	
1 00W 20.9 5.	Usual Residence of Decedent 10a. State 10b. Count MD	NA	10c. City, Town		more					de City Limits
n or 28a-f show tified at ooce.	10e. Street and Number 2002 Jubile				10f. Zip Code	244		10g. Citizen of W		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "oatural", or items 23a or 23a-f shoo injury or other traumatic ereot, the Medical Examiner must be softlifed at loose. To Be Completed by Funeral Director		1 Yes 2		If Ye:	Decedent of Hisps, specify Cuban,	Mexican, Puert			e - American Indian e, etc. Black	, Black,
5-0036 ed within 72 hours aft tygene. other than "catural" the Medical Examine Completed by				Decedent's during mos	S Usual Occupation of working life.	on (Give kind of		16b. Kind of Bu	usiness/Industry	
Baltimore, MD 21215-0036 oermit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumartic ercest, the Medical To Be Comple	Michael Sul	e, Last) Livan			1	Andre	a Wick	Maiden Surname)	
e, MD 21 and 2 should Health and Me item 27 is ma To	19a. Informant's Name/Relation Andrea Wicks 20a. Method of Disposition	-Mother	20b. Place o	OO2 of Dispositi	Jubilee on (Name of cem	Cour		timore,	n, State, Zip Code Md 212 - City or Town, Stat	244
Caltimorrumit. Pages partament of programent of programent. If into or other	1 Burial 2 Crematic	Specify: /	late	22. Na		of Facility	/22/20:	ll Wood	llawn, M	Id
Physician	23a. Part I. Enter the disease, of		d the death. Do no	1 43	00 Waba	ash Av	e Bali or respiratory an	timore. rest, shock, or he	art Approxi	mate Interval
/Medical Examiner	Immediate Cause (Final diseas or condition resulting in death)		on Pneumo sequence of):	onia				<u>-</u>		Death
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death). Last	b. Advanced Due to (or as a cons c. Due to (or as a cons	sequence of):	gical	Disease	2				
60, e e executed system and burial - transit edical Examine	X UNPENDED	d AMENDED # 0								_
lox 6876(eath certificate attending phyfor use as the british	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 V U	the 23c. If yes, outcome the Live birth Pregnant a	a .ptI . 27p ome of pregnancy at time of death 5	Feta	G920 10 death 3 r (Specify)	/13/201 Ectopic pregn		23d. Date of delivery Month Day Yea		
i, P.O. E ires that the d signed by the be detached d by Phy		tions contributing to dear	th but not resulting	in the un	derlying cause giv	ven in Part I.			ibute to the cause of	_
of Vital Records, P.O. of Vital Records, P.O. Wher this certificate has been signed by meral director, page 2 should be detach n: To Be Completed by P							24a. Was autop perfo 1 Ves	psy prmed?	Were autopsy findir oner to completion death? Yes 2	
of Vital Reccing Physiciae: The law After this certificate hauneral director, page 2 nr: To Be Comp.	25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death	- Hospital: -	ent 2 ER/Ou	tpatient	3 DOA		ng Home 5	Residence 6 how injury occurr		
Division of Division of 24 hours after death. Planoral Director: After reely filled in by the funeral al Certification: T	2 Accident Inversion 3 Suicide 6 Cou	(Month, Day, estigation 28e. Place of la			1 Ye	es 2 No		Street and Numb	er or Rural Route N	lumber, City
D To the Hospital within 24 hours To the Fuocral completely filled	29a. Certifier (Check only 1 Certifying I	Physician: To the best of manning: On the basis of examiner: On the basis of examiner stated.	amination and/or in							
A S A S A	29b. Signature and title of certif				29c, License O.C.M			29d. Date sign September	ed <i>(Month, Day</i> , Ye	ar)
Ø		sistant Medical Exa	miner 900 V	V. Baltin	nore Street, E	Baltimore, M	ID 21223			
State	31. Date filed (Month, Day, Year,	32. Registra	ar's Signature	,						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:30 arl Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, or Location of Death 4c. County of Death saltimore If Under Social Security Numb Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Hours Min. May 24, T935 Maryland Director 76 213-32-0649 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Parkville MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 2509 Harwood Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after ð 1 Yes 2 No Specify: Specify: white If Yes, Give 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired. Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha College (1-4 or 5+) Law Enforcement Police Officer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Ellen Margurite Kendall Clifton W. Scruggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2509 Harwood Road-Parkville, Maryland 21234 Audrey Scruggs-spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place)
Crownsville VA Sept. 20,2011 Crownsville, Maryland injury Cemetery 22. Name and Address of Facility Fvans Funeral 21. Signature of Funeral Service Licensee any Chapel and Cremation Services Harford Road-Parkville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Doath Immediate Cause (Final Physician/ Carcinoma Metastatic pa disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Dain to for each consequence of or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year cate has been signed by the page 2 should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 Yes 2 No Yes 2 **D** No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 Nursing Home within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 📆 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Pragioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or

State

Registrar

31. Date filed (Month, Day,

1734 York

Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiens 29902 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3, Time of Death Physician/ 84 Month Year Medical 4a. Facility Name_(if not institution, give street and number) Examiner . City. Town, or Location of Death 4c. County of Death HESAPEAKE Moorcac HARFERD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, 1 1 □ M 2 XX Months Hours Min. Director 59 MARYLAND 219-60-6746 1952 AUG. Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MARYLAND HARFORD CO **EDGEWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1606 MEADOWOOD CT. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify If Yes, Give Year or Dates 3XXWidowed 4 □ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) FR. CHARLES REEP Elementary/Seconday (0-12) College (1-4 or 5+) llyrs CARETAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9/13/11 ည HENRY L. STOKES MARY N. STOKES permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KISHA L SMITH/Daughter 4 YORKTOWN CT., NORTH EAST. MD.20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX urial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) ASBURY U.M.C. 09-24-11 WHITE MARSH, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. PHILA. BLVD., ABERDEEN. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ STATUS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical MODDIG5438 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Dav be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy after death.

Director: After this certificate 2 No Yes 1 🗌 Yes or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) (2 1 Tyes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 Pyes 2 No Division Investigation Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, the Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 [29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, **FP 2 0 2011**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Physician/ Month Thomas William Smith, Sr. 18, September 2011 1:02 A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 991 Regina Drive Halethorpe Baltimore Social Security Number 8. Date of Birth (Month, Day, Jan. 8, 9. Birthplace (State or Foreign Country) Maryland Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 🔀 M 2 🗆 F Days 1949 **Director** 216-56-8413 62 Jan. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 991 Regina Drive 21227 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Yes 2 No Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Security Supervisor Retirement Community Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Smith Edna Mae Kraft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 1 and 2 s of Health item 27 i Marie Ann Smith Wife Regina Drive; Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) idge Mem. Park 9-23-2011 Elkridge, Maryland 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc 1630 Edmondson Avenue; Catonsville, MD 21228 ◆ □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 9-23-2011 21 Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician METASTATIC disease or condition 120VS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical that the death certificate be Box 68760 ding p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery ☐ Live Birth ∠ ☐ Fetal God.
☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 L Yes 2 L 9 L Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed Yes 2 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be HOME 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 7. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 16354

State Registrar

101

Division of Vital

900

CATON AVE BALTIMORE MD21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W COLEMO

AGNES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	1 - State of Maryland / Dep	partment of Health and IV ertificate of Death	, 0	20	11 29904
	Physicia		Decedent's Name (First, Middle, Last) MARJORIE LESLIE SUTTON		2 Date of Death		3. Time of Death 2011 10:32P M
	Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Septembe	4c. County	y of Death
rae l	<i>t</i>		483 Maple Road	Severna Park		Anne	Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear)	Birthplace (State or Foreign Country)
য			Usual Residence of Decedent 1 ☐ M 2 XXF 87 Yrs.		08/18/19	24	New Jersey
	rland F show	tor	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits
	28a-	Director	Maryland Anne Arundel Severna				1 ☐ Yes 2XX No
	ith the		10e. Street and Number	10f. Zip Code			What Country?
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	483 Maple Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	21146 . Was Decedent of Hispanic Origin? (Spe		USA 14 Bac	ce - American Indian,
9	ter de , or it	by	Armed Forces? 1 Never Married XX Married 1 Yes 2XX No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)		ck, White, etc.
9	urs af tural" al Exa	Completed	Year or Dates.	1 ☐ Yes XXX No Specify:		Specify	White
15	72 ho n "nat	nple	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ing 16	6b. Kind of B	Business/Industry
212	vithin giene. er tha		Elementaly/Secondary (U-12) College (1-4 or 5+)	nistrative Assistar	nt	Educ	cation
pu	be filed vental Hygrephe otheric event,	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai		
ylaı	lld be Menta arked	ပ	George Evans Leslie	Elsie W	V i ndhause	n	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			ling Address (Street and Number or Rura Maple Road Severna			
e,	F Healt		20a. Method of Disposition 20b. Place of Disp	· · · · · · · · · · · · · · · · · · ·			- City or Town, State
imo	ant ant			it Crematory 09/16	5/2011 B		ore, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Algnature of Funer 1 de Vicensee	22. Name and Address of Facilitich 6500 York Road Ba	nell-Wiede altimore.	efeld Marvl	Funeral Home Inc
			23a. Part 1. Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
m.	Physician/		Immediate Cause (Final disease or condition	any bypenton	non		Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):				
	3	Jer	Sequentially list conditions, if any, leading to immediate b. Du/ to (or as a consequence of):	my grosse	•		
	uted d ansit	amir	Cause (Disease or injury that initiated events c	1 0			
	exection and an and and and and and and and and	E E	resulting in death) Last Due to (or as a consequence of):				
200	icate be executed physician and is the burial-transit	edical Examiner	d				
9		-	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			234 Do	sto of delivery
Box	eath c atter d for u	iciai	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			ate of delivery onth Day Year
о Ш	ss that the death ceriffi igned by the attending be detached for use a	Physician/N	9 Unknown				
, P.O.	ss that igned be de	ا کر	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			ribute to the cause of death?
rds	requires been sig should b	eted	in its and its	11			3 Probably 4 Unknown
eco	e law r has b ge 2 s	Completed	Achenic Cartho Wa	parag	24a. Was an autopsy performed		Were autopsy findings available prior to completion of cause of death?
Ē.	rsician: The law s certificate has t director, page 2 s		25. Was case referred to riedical	26 Place of Death (Charle	1 Yes 2		1 Yes 2 No
Vita	ysician: T	To Be	examiner? 1	26. Place of Death (Check	me 5 Residenc	o 6 \square Oth	or (Spaniful)
of	ng Phy ter thi neral		27. Manner of Death 28a. Date of injury 28b. Time of	of 28c. Injury at 2	28d. Describe how i		
on	eath. or: Af	ifica	2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Att	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S		er or Rural Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, on	id due to the course	(s) and man	ner as stated
	ne Ho: n 24 h ne Fur pletely	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death	stigation, in my opinion, death occurred at	the time, date and p	lace, and du	e to the cause(s) and manner stated.
	To the within the complete com		29b. Signature and tiple of certifier	29c. License number	29d	Date signer	d (Month Day Year)
)		1 Kulcows	D0054903		29/1	16/2011
			30. Name and address of person who completed cause of death (Item 23a) (Type, Frederick Karkowski mb	D0054903 139 Old Solome	ms Til	and	Rd Annapolis
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, 5 (0/0. 55/0.55			M1) 21401
	Registra	ar .	SFP 2 0 2011 Parmer 14 Brief				

DHMH 17 Rev 06-2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29906 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Shimizu 12:30P^M Hiroshi Sept. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours (Month, Day, Year) **Director** 564**–**54**–**5287 1 XM 2 □ F Aug. 21 1924 Japan Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director Examiner must be notified 1 Yes 2X No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a USA 2525 Pot Spring Rd. #S608 21093 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc by 1 Never Married 2 X Married Japanese 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, Maryland 21 Medical Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Iku Niwa Kiichiro Shimizu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tokuko Shimizu/wife 2525 Pot Spring Rd. #S608, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/24911 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 21093 Dulaney Valley Memorial Gardens 21. Signature of Funeral Se V e of Funeral Se \ e Leensee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Inc. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ MYELOPROLIFERATIVE DISORDER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated see or injury Examine Due to (or as a consequence of) the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes Division of Vital Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? X Natural 5 Pending injury 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature SEP 2 0 2011 State A. pares Registrar

EPTEMBER 15,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
amend #5 Per ANA BD G918 8/123/2011 JH

Reg. No. 0 1 1 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Arthur Russell Smith Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Health System Cumber land Allegany 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F May 7, Day Year) Months Days Hours Min. Director 220-30-8238 Maryland 77 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD 1 Yes 2 No Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 Maple Pl. 21532 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No 1950-Black, White, etc. ρ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. white 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unit (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 10 operator engineer 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Ola Marie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unkpermit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Norma Kasecamp - sister 16714 Watkins RD. NW; Frostburg, MD 21532 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) Signature (Funeral Jervice Lio 22. Name and Address of Facility State Anatomy Board Wade 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🖵 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) this funeral (27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D005400L ann no completed cause of death (Item 23a) (Type, Print) Shiv Chander Khanna Western MD Health System Cumberland, MD 31. Date filed (Month, Day, Year) State SEP 2 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **Betty Scribner** Medical 4a. Facility Name (if not institution, give street and i Town, or Location of Death 4c. County of Death **Examiner** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Oct 15, 1933 1 M 2 X F Months Days Hours Min Country) MD 213-30-2779 77 **Director** Lisual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location Director Yes 2 No **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 U.S.A. 702 Wicklow Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: **Black** If Yes, Give Year or Dates Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Rosewood State Hospital Nurse 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Martha Hawkins Arthur Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5223 Old Frederick Road Baltimore, MD 21229 **Brian Scribner** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burlal 2 🗆 Cremation 3 🗆 Removal from State Sep 23, 2011 Baltimore, Maryland **Arbutus Memorial Park** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 21. Signature of Juneral Service Licensee d the death. 📭 not enter the mode of dying, such as cardiac or respiratory arrest Approximate Onset and Death Immediate Cause (Final ₽nysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to to the attending physician and ned for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 2 X No Yes should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No .24 hours after death. • Funeral Director, After this certificate has be bleted filled in by the funeral director, page 2 s To the Hospital or Attending Physician: The k within 24 hours after death.

To the Funeral Discrete: 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 X No ပ 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa impleted cause of death (Item 23a) (Type, Print 6 V 31. Date filed (Month, Day Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month EUGENE AUGUST STALLINGS P^{M} Medical SEPTEMBE 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death BALTIMORE TIMONIUM GILCHRIST HOSPICE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Hours Director 216-32-3760 76 1 X M 2 □ F 11/14/1934 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No BEL AIR MD HARFORD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21014 816 TURTLECREEK CT death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No WHITE Specify: "natural" 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " ARMY CORP OF Elementary/Secondary (0-12) College (1-4 or 5+) CIVIL ENGINEER ENGINEERS and Mental Hygie is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ELEANOR EMGE FRANCIS STALLINGS 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is ANN STALLINGS-WIFE 816 TURTLECREEK CT BEL AIR, MD 21014 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State GLEN BURNIE, MD 9/19/11 ATLANTÍC CRÉMATORY 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELAIR MD 21014 MACPHAIL RD BEL AIR, 610 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) yen(Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physiclan d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicle Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence completely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat 29d. Date signed (Month, Day, Year) september 15 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6101 31. Date filed (Month, 32. Redistrar's 2011

DHMH 17 Rev 06-2011

Registrar

20

				Please	e Type or Pri						-		_	ble.		
			For State		State of M	larylan					Mental H	ygien	е			
			Registrar	- (F) - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -			Cei	rtifica	te of L	Death		Reg. N	501		2991	U
	Physici Medi		1. Decedent's Nam	11	ee Su	Mive	an				2. Date of D Month Sept			Year 2011	3. Time of De	
	Exami	ner		1/1	e street and number)	14	211	4b. Cit	1 /	Location of Dea	ath /	4	c. County o	f Death		
	Funeral		5. Social Security N		bex 7. Ac	e (In yrs. 4	st birthday)		er 1 Year	If Under 24 H		irth	Mowa	9. Birth	place (State or F	oreign
	Director		048-24-4 Usual Residence o	1044	1 □ M 2 x F		82 Yrs.	Month	s Days	Hours Mi	n. 1 ^{Month} 2 5	3º 1° 9° 2	28 C	onne	cticut	
	yland -f sho ed at	ctor	10a. State	10b. County	1	10c. Cit	y, Town or Lo							1	0d. Inside City I	
	ne Mar or 28a notifi	Dire	MD 10e. Street and Nu	Howa	ırd	<u></u>	Col	umbi	a Zip Code			100 0	Citizen of Wh	ant Cour	1 Yes 2	X No
	with the s 23a c	Funeral Director		Transfer	Row			101. 2		1045		Tog. C		.S.A	-	
	death item		11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	6. 13. \	Was Dec	edent of Hi	ispanic Origin? (In. Mexican, Pue	Specify Yes or No rto Rican, etc.))	14. Race	- Americ		
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Mar 3 ☐ Widowed	ried 2 Ma <i>m</i> ied 4 X Divorced	1 Yes 2X If Yes, Give Year or Dates.	4No	- 1			Specify:	, , ,		Specify:		hite	
5-0	2 hour "natu edical	plet	(Spe	15. Decedent's i			16a. Deced			ation during most of w	orkina	16b.	Kind of Bus	iness Inc	dustry	•
121	ithin 7. ene. • than	Completed	Elementary/Sec	onday (0-12)	College (1-4 or	5+)	life. Di Healt	O NOT u	se retired)	iding moot of m	orinig		Howard blic S		unty ol Syst	em
od 2	filed w at Hygi I other vent, t	Be	17. Father's Name				nearc	.11 A.1	.ue	18. Mother's N	ame (First, Middle	e, Maider	n Surname)			
ylaı	uld be Menta narked natic e	2	Leo Ha				_			Helen_						
Mai	2 should Ith and M 27 is mar traumati		19a. Informant's N Melissa	ame/Relationship (Fields	Type, Print) (Daughter))				and Number or F ire Way	Rural Route Numb:				Code)	
ore,	1 and of Hea fitem		20a. Method of Dis	position		20b. P	lace of Dispo	sition (Na	ame of		Date	<u> </u>	Location - C		wn, State	
Baltimore, Maryland 21215-0036	Page tment o tant: If jury or			X☐ Cremation 3 L 5 ☐ Other (Spec	Removal from State		lantic				15-2011	G:	len Bu	ırni	e, MD	
Bal	permit. Departr Importa any inju		21. Signature of Fu	ne Service Licer	gee de	2				ss of Facility V Knolls	litzke Fr Columbi	unera	al Hor MD 210	nes,	Inc.	
			23a. Part 1. Enter	the disease, or con	aplications that caused one cause on each line	the death								T	Approximate	
1	Physician/		Immediate Cause disease or condition	Final		29	Ca	MC	"er						Onset and Dea	
ann.	Medical Examiner		resulting in death)	•	Due to (or as	a consequ										
		ner	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate	b. Due to (or as	a consequ	ence of):							+		
	executed an and rial-transit	Examiner	Cause (Disease or that initiated event	linjury s	c											
	0 7 7	ज्ञ	resulting in death)	Last	Due to (or as	a consequ	ence of):									
1760	certificate be nding physici use as the bu	Nedic		-	d			_						\pm		
Box 68760	eath certificate be attending physic I for use as the b	an/N	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome 1 Live Birth	of pregnai	ncy	Ectopic	oregnanc	v			23d. Date	of delive	ery	
Bo	9 9 G	by Physician/Medic	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No No	4 ☐ Pregnant a g ☐ Unknown			Other (,			Mont	h	Day Yea	r
P.0.	requires that the dea been signed by the a should be detached f	y Ph	Part II. Other signit	icant conditions	ontributing to death b	ut not resi	ulting in the u	nderlying	cause giv	en in Part I.	23e. Did	tobacco	use contrib	ute to th	e cause of deat	:h?
	been sign	ted b									. 1 🗆	Yes 2	2 🗆 No 3	Prot	oably 4 🗆 Unl	known
of Vital Records,	2 S S	Completed									24a. Wa	opsy	pri	or to coi	osy findings ava	ilable se of
Re	The ate page	Col	05.14								per 1 🗆 Yes	formed?		ath? Yes	2 🗆 No	
/ital	Physician: The this certificate ral director, pag) Be	25. Was case referr examiner? 1 ☐ Yes 2 E	ed to medical No	Hospital:				104	ace of Death (Ch						
of \	g Phy er this neral d	te: To	27. Manner Deat	1	28a. Date of inju	rv	ER/Outpatien 28b. Time of		28c. Injury	at Nursing	Home 5 Res					
ion	Attending or death. Sector. After by the funer	ifica	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigatio 6 ☐ Could not b	n	, rear)	injury	М	work	? Yes 2 □ No						
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director.	Certificate:	4 Homicide	determined	28e. Place of Inju building, etc	iry - At hoi :. (Specify)	me, farm, stre	et, facto	ry, office		28f. Location City or To			or Rural	Route Number,	
	Hospital or 24 hours affe Funeral Dire sted filled in I	Medical	29a. Certifier 1 (Check 2	Certifying Phy	sician: To the best of iner: On the basis of e	my knowle	edge, death o	ccured a	t the time,	date and place,	and due to the c	ause(s) a	ınd manner	as state	d.	
	To the H within 24 To the Fi complete		only one) 3	Certifying Nur	se Practioner: To the	best of my	knowledge, d	eath occ	urred at the	time, date and p	d at the time, date place, and due to t	he cause	(s) and man	ner as sta	ated.	r stated.
	5 ≥ 6 8		29b. Signature and	Miller		MI)	29	D 6	number 4870			ate signed (
			30. Name and addre	ss of person who	completed cause of d	eath (Item	23a) (Type, P	rint)				-7	, ,			
10			SI	rahar.	Ba	Mi	w,	Howa	rd Co	ounty Ge	n. Hosp	<u>ital</u>	Co1m	nbia	,MD 2	1045
	Sta Registra		31. Date filed (Mont	1, Day, Year) 2 0 2011	32. Registra	ır's Simatu	Mark	1								

11-06899 Julio Salgado Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ulio Salgado		1- For State Registrar	tate of Maryla		ertificate of		d Mental	F	Reg. No. 201	1 29911
Physicia Medical Examir			esto Salga					2. Date of Dea Month Septemb	Day Year er 13, 2011	3. Time of Death 0031 hrs
		4a. Facility Name (if not instituti 915 Dulaney Valle Co		ımber)		lb. City, Town, or Towson	Location of De	eath	4c. County of t Baltimore	
Funeral Director		5. Social Security Number 215-63-0696	6. Sex	7. Age (In yrs.	•	If Under 1 Year Months Day		Min	11-	Birthplace (fitate or oreign Country Salvador
	ŀ	Usual Residence of Decedent	14-4-M 2F		21 Yrs			03/1	6/1990	
w any		10a. State 10b. County		10c. City	y, Town or Locat					10d. Inside City Limits
yland	흱	MD How 10e. Street and Number	ard			umbia		1	10g. Citizen of What	1 Yes 2 X No
th the Maryland 23a or 28a-f shu uotified at once.	Director	6048 Charles	Edward Te	errace		210	45		U.S.A.	ood.n.y.
h with 1	Funeral	11. Marital Status		edent Ever in U		Decedent of Hises, specify Cubar		(Specity Yes or N	o- 14. Race - A White, e	American Indian, Black,
er death		1 X Never Married 2 N	Aarried 1 Yes	2 X No			E1.	salvadora		l Salvadoran
ours afi atural'	<u>ة</u>	15. Decedent's Education (Spe	or Dates:		16a. Deceden	's Usual Occupa	tion (Give kind	of work done	16b. Kind of Busin	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "bastural?, ar items 23a or 28a-f sha actic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)) College (1	-4 or 5+)		ost of working life cudent	. DO NOT use	retired)	Studen	t
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle	e, Last)						Maiden Surname)	
2121; nuld be fill Mental F marked c event, i	Be	Jose Salgado 19a. Informant's Name/Relation:	ehin (Tune Print)		10h Mailine	Address (Street			na Medran	
	잍	Yesenia Salgad		er)						a, MD 21045
		20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Removal fr		Place of Dispos crematory or oth		metery,	Date	20c. Location - Ci	ty or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If itelinjury or other tr		4 Donation 5 Other S	Specify:		lantic			-16-2011		rnie, MD
Bal permij Depar Impo		21. Signature of Funeral Service	Licepsee			ame and Address 55 Twin	s of Facility Kolls I	Witzke Fu Road Col	ineral Hon umbia, MD	nes. Inc. 21045
Physician /Medical	┪	23. Part I. Enter the disease, o failure. List only one cause		aused the death						Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	e a. <u>Oxycod</u> Due to (or as a	one and	Alcoho	l Intoxi	cation			Death
•		Sequentially list conditions,	b		,					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C							
d d ansit	Exa	events resulting in death) Last	Due to (or as a d.	consequence of	of):					
O, be executed sician and burial - transit	dical Gal	★ UNPENDED		23a,27,	28a-f,p	er me,g9	19 9-30)-11 sm		
18760 rtificate t	യ ⊨	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, on the	outcome of preg		al death 3	Ectopic pre	onancy	23d. Date of de Month	livery Day Year
Box 6876 e death certificate the attending phy of for use as the t	Physician/M	past 12 months? 1 Yes 2 No 9 Un	4 Pregn	ant at time of de	ooth -	er (Specify)		gridinoy		Say Tour
C. BC t the de-		Part II. Other significant condi	9 OIINIK		resulting in the u	nderlying cause (given in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detach.	اق							_ 1 _ Ye	s 2 No 3	Probably 4 Unknown
cords,	Completed							24a. Was	psy prio	re autopsy findings available r to completion of cause of
tal Rec	5							1 ✓ Yes		Yes 2 No
Vital Physician: hysician: this certifi	o Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hoenital:	npatient 2	ER/Outpatient		of Death (Che		Residence 6	Other: Scene
ling Ph	⊢⊦	27. Manner of Death		of Injury Day,Year)	28b. Time of Ir		ry at Work?		how injury occurred	l oxycodone and
IVISIOR or Attend after death Director:	catio	2 X Accident Inve	estigation 10 9	-13-11	fd 12:0	1 2011	Yes 2 X No	alcoho	1	or Rural Route Number, City
DIVI	Certification:		Ild not be ermined (Specify)	resid		, ractory, omeo E	randing, oto.	#A Tow	State) 915 Dul son, MD.	aney Valle Ct
8 - 3 > 1	Medical C		Physician: To the bes	f examination a				and due to the cau	se(s) and manner as	stated.
F 3 F 8	¥.	29b. Signature and title of certific	and manner st er	/ /	17	29c. Licens				(Month, Day, Year)
			2-6	>/		O.C.I	M.E.		September 1	3, 2011
6		30. Name and address of persor Russell Alexander MD	D. Assistant M	,	•	V. Baltimore	Street, Bal	timore, MD 21	223	
Sta Registr	te	31. Date filed (Motified)	2011 32.5	gistraris Signati		21				
registi	للت				17. ASE	Kel				

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Michael Siegel 11-06901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK		1- For State	tate of Maryla			of Healt of Death		Mental H		ea. No. 201	1 29912
Physici	ian/	Registrar 1. Decedent's Name (First, Midd	dle,Last)						2. Date of Deat	th	3. Time of Death
Medical Exam		MICHAEL	JESSI	Ξ		SIEGE	Τ.		Month Septembe	Day Year r 13, 2011	0224 hrs
		4a. Facility Name (if not instituti	on, give street and nu	mber)		4b. City, To	own, or Lo	cation of Death		4c. County of E	
		4433 East Joppa Roa				White				Baltimore	
Funeral Director		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	r 1 Year Days	If Under 24Hrs Hours Min	_		Birthplace (State or oreign
Director		212-98-9797	1XM 2F	32	2`	rs.	Days	Tiodis IVIII		3/1979	Country) MD
uà.		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	ration					10d. Inside City Limits
1 10 W 2											1 Yes 2 X No
Maryland 28a-f show any d at once.	탾	MD BAL 10e. Street and Number	TIMORE		PERRY	HALL 10f. Zip (Code		14	Og. Citizen of What	
e Ma or 28	Director	9 OFFSPRING	COUDE						1		Country
death with the Maryland or items 23a or 28a-f sho must be notified at once.	a	11. Marital Status		edent Ever in U	IS 13 V		1128	nic Origin? (S	pecify Yes or No-	USA	merican Indian, Black,
eath v item	Funeral	1 XXNever Married 2 N	larried Armed Fo	rces?				flexican, Puerto		White, e	
fter d		3 Widowed 4 Di	1 Yes vorced If Yes, Give Yea	2 XX No	1	Yes 2	X No s	specify:		Specify:	WHITE
5-0036 led within 72 hours afte dygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Spe	ecify only highest grad	le completed)				(Give kind of		16b. Kind of Busine	
6 172 h 118 m	lete	Elementary/Secondary (0-12)	College (1	-4 or 5+)	auring	most of work	ing lite. Di	O NOT use ret	ired)		
15-003(filed within Hygiene. d other tha	Completed	12			AS	SISTAN'				RESTAU	URANT
15- filed Hyg		17. Father's Name (First, Middle	, Last)						(First, Middle, M	flaiden Surname)	
D 2121 should be f and Mental 7 is marked	To Be	DENNIS 19a. Informant's Name/Relations	ship (Type Print)	SIEGEI		ing Address		ALICE	Pural Pauta Num	ber, City or Town, S	WEITZEL
MD 21215-0036 12 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 127 is marked other than "natural", or items 23a or 28a-fabo umatic event, the Medical Examiner must be notified at once	-	ALICE SIEGEL			4				PERRY HA		21128
e, N I and Health item		20a. Method of Disposition			Place of Disp	osition (Name	of cemet	ery,	Date	20c. Location - Cit	
nor ages 1 nt of 1 ft: If		1 Burial 2 Crematio		om State GAI	crematory or RDENS (other place) OF FAI'	гн мғ	EM OO /	16/0011		
Baltimore, MI permit. Pages 1 and 2.5 Department of Health a Important: If item 27 injury or other traum		4 Donation 5 Other S 21. Signature of Funeral Service		IPAF	RK _	Name and A	ddress of		16/2011		MORE, MD
E Per B	l. U	Ser -						DU.	L LEVINS	SON & BROSPIKESVILLE	S., INC. E, MD 21208
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca	used the death	. Do not ente	the mode of	dying, suc	ch as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval
Madical xaminer		Immediate Cause (Final disease		ıg							Between Onset and Death
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or condition resulting in death)	Due to (or as a	consequence o	of):						
	5	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence o	of):						
	튑	cause. Enter Underlying Cause (Disease or injury that initiated	C								
ted Insit	Examiner	events resulting in death) Last	Due to (or as a	consequence o	t):						
OX 68760, sath certificate be executed attending physician and for use as the burial - transi	dical	X UNPENDED	d AMENDED	23a,27,	28a-f	per me	92	0 10-5-	-11 vt		
760 icate b	₹	IF FEMALE: 23b. Was decedent pregnant in ti		utcome of preg	nancy					23d. Date of del	ivery
certif	lä	past 12 months?	I LIVE DI	rth ant at time of de	ath ~ 🖂	etal death		Ectopic pregna	incy	Month	Day Year
Box 68760 re death certificate by the attending physical for use as the bit.	Physician/Me	1 Yes 2 No 9 Un	known 9 Unkno		2 🗌 (Other (Specif	y)			2	1
at the		Part il. Other significant condit	ions contributing to	death but not re	esulting in the	underlying c	ause give	n in Part I.	23e. Did tol	bacco use contribute	e to the cause of death?
ords, P.O. ov requires that the as been signed by the should be detached	od by								1 Yes	2 🗸 No 3	Probably 4 Unknown
ord: w requires been should	Completed								24a. Was a autops		e autopsy findings available to completion of cause of
Reco The law icate has page 2 sl	E								perform 1 ✓ Yes 2		h? Yes 2 No
Vital Reorysician: The his certificate director, page	Be	25. Was case referred to medica examiner?				26		Death (Check	only one)		
Mysic all dire	2	1 ✓ Yes 2 No	Hospital: 1 Ir	patient 2	ER/Outpatie	nt 3 DO	A Oth	er4 Nursin	g Home 5 F	Residence 6 🗹 0	ther: Scene
ion of tending Pheath.	티	27. Manner of Death 1 Natural 5 Reserved		of Injury Day,Year)	28b. Time o		c. Injury a		28d. Describe h	ow injury occurred	
ivision or Attendather death Director:	實	Fenc	stigation I a 9-	-13–11	fd 2:	Lyam		2 x No		t hanged	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detected.	Certification:	. C dete	a not be	of Injury - At ho		eet, factory, c	ffice build		or Town, St	ate) 4433]	Rural Route Number, City E. Joppa Rd.
lospit 4 hour uners		4 Homicide	(Opeciny)	1ocal		urad at the "	mo dete		Perry Ha	111, Md.	
Division of Vital Records, P.O. Box 68760 within 24 hours after death. The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical		nysician: To the best miner: On the basis of	examination ar							
H. P. F. S.	¥	29b. Signature and title of certifie	and manner sta	ited.	, .	29c. l	icense nu	umber		29d. Date signed	(Month, Day, Year)
		MAM	C		RI	$) \mid \langle$	O.C.M.E	Ξ.		September 13	3, 2011
1	ŀ	30. Name and address of person		death (Item	23a)						
y		Russell Alexander MD					nore Sti	reet, Baltim	ore, MD 212	23	
St Regist	ate rar	31. Date filed (Month Day Year)	2011 32 Reg	jistrar's Signatu	1. 400	Mad					
			7		4.0						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#18perFH, G920, 107 572011, WS

State of Maryland / Department of Health and Mental Hygiege Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day Month **Physician** 2010 PM xander α 13,2011 5-01 Ter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner nion attma a If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Sirthplace (State or Foreign Country) 6. Sex M 2 ☐ F 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 68 Yrs. Months -939 une. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show s 1 and 2 should be illed within 72 hours effer deeth with the Maryla if Heelth and Mental Hygiene.
Item 27 is marked other than "natural", or iteme 23a or 28a-f ehoy other traumatic event, the Macilcal Examinar must be nutified at Yes 2 No Director Iti more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2/206 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married 1 Yes 2 No. Specify: Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber 10 18. Mother's Name (First, Middle, Maiden Syr Georgianna Tabb 17. Father's Name (First, Middle, Last) Be Johnson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type, Print) altimore 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Peges 1
Depertment of H
Importent: If ite
any injury or ott 19/2011 Bathmore 4 Donation 5 ☐ Other (Specify) 21. Superive of Funeral Service Licensee towell Funera Home 22. Name and Address of Facility Hae, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Muscardio Physician mins /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the deeth certificate be executed buriai-transli Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien if for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? signed by the et id be detached fo 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has pege 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: After this certifice funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 1 Yes 2 No 5 Residence 6 Other (Specify) ۵ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; Injun 1 Natural 5 Pending 2 🗌 No death. 1 Tyes within 24 hours efter death. To the Funerel Director: A completely filled in by the fi investigation thef 2 Accident 6 Could not be determined 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide f ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sex 13. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) East Inversi 31. Date filed (Month, Day, Year) 92. Registrar's Signature State SFP 2 0 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month H. Richard Thobe September 18,2011 4:20P Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Stella Maris Timonium Balto. 6. Sex 8. Date of Birth
(Month, Day, Year)
August 31,1926 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 219-10-3851 **Director** 1 ▼ M 2 □ F 85 Yrs Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Balto. Parkville 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code 10a. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 8851 Wilson Avenue 21234 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 1944—1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Completed 3 Widowed 4 Divorced Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 injury or other traumatic Karl T. Thobe Katie Erbe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, DTR. Katherine Vollmer Perry Hall, Md. 21128 4205 Silver Spring Rd. 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 9-21-2011 Moreland Parkville, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek FuneralHome 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition PARKINSONS DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Box 68760 Records, P.O.

p.m.

SEPTEMBER 18.

State

Completed autopsy Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29c. License number of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TIMONIUM, MD 21093

1 Yes 2 No

HOSPICE

Registrar

JACKIE JONES,

31. Date filed (Month, Day, Year)

CRNP

2 0 2011

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 16 Physician/ Ruth Ε. Updike September 2011 05:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbour Rehab Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 578-24-5783 **Director** 1 M 2 X F 86 Dec. 14, 1924 DC Usual Residence of Deceden 28a-f show Medical Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2819 Berth Terrace 21401 IISA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 🔀 No 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 X Widowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) and 2 should be filed within Health and Mental Hygiene. College (1-4 or 5+) the 12 Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٥ George Sours Pauline Lombord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Wayne Updike (son) 416 Colonial Ridge Lane, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Sept. ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metro Crematory Inc. 4 Donation 5 Other (Specify) Baltimore, Maryland 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD tion sthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complical shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ aeduac disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day g Unknowh Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 1 Yes Z No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending after death. 1 Yes 2 No Investigation completely filled in by the 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and tit

Registrar
DHMH 17 Rev 06-2011

30. Name and address

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

n who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 17, 2011 Dorothy Lea VanDevander 1:42 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing & Wellness Center Montgomery Rockville . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth June 20, 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 1 🗆 M 2 🕱 F Months 233-48-2805 78 ^{^e}1933 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland | Montgomery 1 Yes 2 X No Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 United States 13010 Turkey Branch Parkway 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 Never Married 2 🔀 Married Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2 No Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lead Assembler Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Wilson Carrie Kisamore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Jennings VanDevander / Husband 13010 Turkey Branch Parkway, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Parklawn Memorial Park 2011 Rockville, Maryland Signature A Funeral Service Lensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, 300 West Montgomery Avenue, Rockville, Maryland 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate

Physician/ Medical Examiner

Physician/

Medical

Director

ρ

Completed

Be

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.

Baltimore, Maryland 21215-0036

differents. To De Oemmeleked by Dheering Man deel Evenue

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed

certificate ha

	Immediate Cause (Final disease or condition resulting in death)	a. Failure to thrive Due to (or as a consequence of):		Onset and Death month
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. — Due to (or as a consequence of): c. — Due to (or as a consequence of): d		
ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of de Month	livery Day Year
Completed by Physician/Medical Examiner	Part II. Other significant conditions of End Stage Dement	cia	autopsy prior to performed? performed?	
Be (25. Was case referred to medical examiner?	26. Place of Death (Check only		
2	1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5	☐ Residence 6 ☐ Other (Spec	ifv)
ficate:	27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 Yes 2 No	Describe how injury occurred	
Medical Certificate:	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. L	ocation (Street and Number or Rui ity or Town, State)	ral Route Number,
Medica	(Check 2 ☐ Medical Exam only one) 3 ☐ Certifying Nur	sician: To the best of my knowledge, death occured at the time, date and place, and due ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time se Practioner: To the best of my knowledge, death occurred at the time, date and place, and	me date and place and due to the	cause(s) and manner stated
	29b. Signature and title of certifier	29c License number	20-1 D-11-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	Day Marak

R113971

September 19, 2011

State Registrar Mary Haynos, CRNP, 10110 Molecular Drive Suite 206, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygien 20 | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 10 2011 Trinita Whitehead September 6:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death FutureCare - Sandtown Wichester Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) UNK **Funeral** 8. Date of Birth (Month, Day, Year) ine 11, 1937 1 □ M 2 🛣 F Days **Director** 579-50-7363 June Usual Residence of Decedent 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 21217 10g. Citizen of What Country? Funeral 1402 McCullough St. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married g Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) domestic work laborer Be 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore City Commission on Aging
5220 York Rd; Baltimore, MD 21212 Freida Jones - guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) 22. Name and Address of Facility State Anatomy Board Licensee S. Wante Ronald Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPERTENSIVE CARDIOVASCHEAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 ☐ Yes 2 > 9 ☐ Unknown s been signed by the s should be detached 9 Unknown Part II. **Oth**er s**ignificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\</u> DEMENTIA Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 2 No 1 Tes **Division of Vital** the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

UMA

m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D0059107

BUSINESS CENTER PRIVE REISTERSTOWN

			Plea	_	•							II Copie		_	ible.		
		For State		S	State of I	Marylaı		artme <i>rtifica</i>			nd M	lental Hy		0.0	1.1	20	0.1.0
		Registrar 1. Decedent's Name	e (First, Middle	, Last)				Tinca	ie Oi L	Calli	_	2. Date of De	Reg. No	<u> </u>	-1-1-	3. Time	e of Death
Physicia Medic		Hassan 1	D. Zer	eshk:	i							Septe	nbei	r 13,	2011	10:4	4 PM
Examin	er		Regio	nal	Hospi	tal			Lo	Location of				c. County	ce (rge's
Funeral Director		5. Social Security No. 678-70-7		6. Sex 1 🕅 M	2 🗆 F	Age (In yrs. 65	last birthday) Yrs.	Months	er 1 Year Days	If Under 24 Hours		8. Date of Bi	rth ay, Ye <i>ar</i>)	946	9. Birth Cour Irar	place (Stat stry) 1	te or Foreign
d tow		Usual Residence of 10a. State	Decedent 10b. County				ity, Town or L	ocation	-								City Limits
farylan Ba-f sh tified a	ecto	MD	Anne A	Arunde	el	Lau		ocation									Yes 2 X No
with the N s 23a or 28 ust be not	Funeral Director	10e. Street and Nun		rt Mea	ade Rd	. #10	9	10f. Z 207	ip Code 724				10g. C	itizen of V	Vhat Cou	ntry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment of Health and Mental Hygiene. any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 XNever Marri 3 Widowed		ried	Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? X No	If Yes, specify Cuban, Mexican, Puerto Rican, etc								e - Americ k, White, Whi		
72 hours "natur ledical B	Completed	(Spe	15. Deceder cify o <i>nly high</i> e	nt's Educat	ion		(Give	edent's Us e kind of w	ork done d	ation luring most o	of worki	ng	16b. f	Kind of Bu			
d within lygiene. ther than it, the M	Be Con	Elementary/Seco			College (1-4 o	or 5+)	Hotwa		se retirea)					rougł		Rac	ing
l be filed fental H rked of tic ever	To B	17. Father's Name (I	First, Middle, L	.ast)				(ı	ınk)	18. Mother' (unk)		e (First, Middle	, Maiden	Surname)		(unk)
12 should alth and N 27 is ma r trauma		19a. Informant's Na Arturo P						-				urel, I			tate, Zip	Code)	
age 1 and ent of Hez nt: If item y or othe		20a. Method of Disp 1 Burial 2 4 Donation	X Cremation		oval from Sta	oto	Place of Disp cemetery, cre al Jou	matory or	other place	e) atorv		Date 20/11		dbine			
permit. F Departm Importal any injui		21. Signature of Fur		,	0.44						-	n Serv			<u> </u>		21020
	П	23a. Part 1. Enter the shock, or hear							-					<u>arks</u>	<u> </u>	Approxir Interval	mate
Physician/ Medical		Immediate Cause (disease or conditio resulting in death)		a	Due to (or a	teral	mence off:	umo								2 W	nd Death REKS
Examiner	ıer	Sequentially list con	nditions, mediate	b. –	Cere		dSCU	ar 1	4cci	dent			. =				
executed ian and irial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):															
ate be ex shysician the burial																	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		If yes, outcor 1 Live Birt 4 Pregnan 9 Unknow	h 2 🗌 Fe tat time of	tal death 3	☐ Ectopic		у			23d. Date of delivery Month Day			Year	
ires that the signed by the detail		Part II. Other signif		ns contrib		h but not re	sulting in the	underlying	cause giv	en in Part I.				use contri			of death? X Unknown
The law requested has been page 2 shou	Completed by												psy ormed?	p		mpletion	gs available of cause of
sian: T ertifica ctor, p	Be C	25. Was case referre	ed to medical							ace of Death	(Check	1 \(\superset \text{Yes}\)	2 (A)	10] .		2 (23)110	
Physic this coral dire	은	1 Yes 2	€ No	Hosp	1 X Inp 28a. Date of i		ER/Outpatie			4 L Nurs		me 5 Res)	
ending eath. or: After ne funer	Certificate:	1 XNatural 2 ☐ Accident	5 Pendin	g gation		Day, Year)	injury	M	28c. Injury work' 1 🔲			28d. Describe	now inju	ry occurre	ea		
to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director.	ıl Certii	3 ∐ Suicide 4 ☐ Homicide	6 ☐ Could determ		8e. Place of building,	Injury - At h etc. <i>(Specii</i>	ome, farm, st	treet, facto	ry, office			28f. Location (City or To			r or Rura	l Route Nu	mber,
he Hospi in 24 hou he Funer pleted fill	Medical	(Check 2	Certifying Medical E Certifying	xaminer: (On the basis of	of examination	on and/or inve	stigation, in	n my opinio	n, death occi	urred at	the time, date	and plac	e, and due	to the ca	use(s) and	manner stated
To t with To t com		29b. Signature and	title of certifier	-	ab (سر	M.	29	c. License	2472	21			ate signed ptem			2011
9		30. Name and address Syed A.	Sadiq,			f death (Iter	n 23a) (Type, Laure	Print) Bou	ieRo	di, Su	iite	208	Lac	irel,	MI	20	708
Stat Registra		31. Date filed (Monti			1	strar's Sign	ature										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BoonSboroMi) ashine ton temona 5. Social Security Number 104-28-6157 If Under 1 Y 9. Birthplace (State or Foreign Funeral Age (In yrs. last birthday) 8. Date of Birth 1 3 M 2 🗆 F Months Min. Maryland Director Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Sabillasville Maryland Frederick 1 🗌 Yes 2 💢 No 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 17232 Sabillasville Road 21780 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1955If Yes, Give Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: 3 Widowed 4 Divorced Year or Dates. 1963 white any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) be filed within College (1-4 or 5+) State of Maryland Food Delivery Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental P Mental 2 Norman Adams Helen Snyder permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell Stottlemyer, son P.O. Box 313, Fairfield, PA 17320 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Sometherpry, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/31/2011 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD Carroll Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home Emmitsburg, MD 21727 R 210 W Main St, Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or is a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Jialsete. Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALES 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide
Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Ecertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 8/25/11 WJL Carp Lema + 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Court Hagerstown, HD 21740

State Registrar Mana

31. Date filed (Month Day,

Ylandhau

1124

Opal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month C Physician/ catrice Atkinsor 0925 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arundal Anne Anne Anunde Center Annapo Funeral Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) 8. Date of Birth 1 🗆 M 2 🔀 F Months June 17, 1921 Hours Min. 579-32-1164 Director 90 Virginia Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10b County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Anne Arundel Severna Park 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 859 Cottonwood Road 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dietician 4 Health Care Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Bennie Draper Annie Upson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Nora Spicer/Daughter 1817 Chester Drive Chester, MD 21619 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other Date 31, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Aug. 2011 Metro Crematory 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy. P.A. Severna Park Funeral H Severna Park, MD 21146 23a. Part 1. Exter the hisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart latiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ostridium difficile Medical Due to (or as a consequence of): Examiner Antibiohic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ng physician and as the burial-transit Exami that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Preumani Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 \quad Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident Investigation 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 2011 072034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rebecca Powell

Registrar

State

Medi

AUG 3 1 2011

31. Date filed (Month, Day, Ye

Baltimore, Maryland 21215-0036

Box 68760

P.O.

of Vital

Division

Dark

Annapolis

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Adkins Gene Gordy 2011 6:41 A^{M} Medical August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wicomico 9105 Hampton Court Delmar 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Director 215-62-1904 58 1 X M 2 □ F May 29, Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21875 9105 Hampton Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1

X Yes 2 □ No 1972-If Yes, specify Cuban, Mexican, Puerto Rican, etc Black, White, etc. by 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes. Give 3 Widowed 4 Divorced white 1976 Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) correctional officer prison Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lloyd Adkins Lura Gordy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Adkins (Wife) 9105 Hampton Court Delmar, MD 21875 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware Crematory of Delmarva 08-25-2011 21. Signature of Funeral Service Licensee Name and Address of Facility Short Funeral Home 13 East Grove Street 19940 Delmar, DE enter the disease, or complications failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1 shock Interval Retween Onset and Death Immediate Cause (Final Ph sician/ Metrotata disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No sate has been signed by the apage 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, it 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? Natural Acciden 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 29b. Signature and title of certifie 29c. License number 038709 30. Name and add s of person who completed cause of death (Item 23a) (Type, Print)

State Registrar いファ

50

Fally Rd

Shartma

lliar

#415 (challe,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald Lee Adkins 0254 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death VICIMICS 1 Year If Under 24 Ars 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday, DE Country) (Month, Day, Year 6-2-194 1 **X** M 2 □ F Months Davs Hours Director 70 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at 10d. Inside City Limits Director 28a-f 1 Tes 2 XNo Sussex Dagsboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i by Funeral 30673 Bunting Road 19937 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. If Yes, Give SpecWhite 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Farmer/Butcher</u> Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ Alice Godfrey Layton Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau David Godwin/Grandson 30697 Bunting Road, Dagsboro, DE 19939 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place). 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 ☐ Bornation 5 ☐ Other (Specify) 8-25-2011 Cremation/ Dover, DE permit. 22. Name and Address of Facility 917 Bennie Smith Signature of Juneral Service Licensee W. Isabella St. Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a onsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner sequence of): sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death n signed by the a 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant, conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No has prior to completion of cause of death? this certificate 2 🗆 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death, upleted filled in by the funeral Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) PIC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 30, 2011 1:29 Рм Marjorie Levia Adams Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Caroline Home for Hospice Denton 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Maryland 8. Date of Birth 6. Sex . Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🟋 F Days April 10, Year) Months Hours Min Director Yrs. <u>215-16-3032</u> Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Caroline Denton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21629 9921 Bates Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 H.S. Grad. Farmer's wife <u>Family</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Eliza Breeding Charles Henry Butler, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 27170 Enniskillen Road, Easton, Maryland 21601 Janet Lee Adams/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sept. 6, 2011 | Denton, Maryland 4 Donation 5 Other (Specify) Denton Cemetery 21. Signature of Funeral Service License Moore Funeral Home, P.A. 22. Name and Address of Facility Denton, Maryland 21629 South Second Street, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LYMPHOMA Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami law requires that the death certificate be executed Cause (Disease or inijury that initiated events resulting in death) Last and trar Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnam 9 ☐ Unknown signed by the a ld be detached fi g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has a autopsy performed the Hospital or Attending Physician: The Ithin 24 hours after death.

the Funeral Director: After this certificate himpleted filled in by the funeral director, page Yes 2 1 Yes 25. Was case referred to cal examiner? 26. Place of Death (Check only one) Be Hospital: Other: HOSPICE HOUSE 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) D0068042 2011 August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohan 21639 mo State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		1	For State Registrar	State of Marylan		tificate of Death	and Montainly	Reg. N2		29925	
	ysicia	n/	Decedent's Name (First, Middle, Last) Katherine	Ann.		Bell.	2. Date of De Sept 7,		Year	3. Time of Death 8:30 A M	
	Medic xamin		4a. Facility Name (if not institution, give s 2514 Fairhill Drive	treet and number)		4b. City, Town, or Location	of Death		unty of Death	of Death • George's	
	neral ector		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs.		er 24 Hrs. 8. Date of Bir Min. (Month, Da July 15	y, Year)	g. Birthp Coun New	olace (State or Foreign try) York	
iryland	ied at	I ⊩	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo		y, Town or Loo Suitlan				1	0d. Inside City Limits 1 ☐ Yes 2 No	
vith the Ma	23a or 28a ist be notif	eral Dire	10e. Street and Number 2514 Fairhill Drive			10f. Zip Code 20746		Ü	of What Cour	ntry?	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	Iral", or items Examiner mu	by F		12. Was Decedent Ever in U.s Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.	1	Vas Decedent of Hispanic O Yes, specify Cuban, Mexica ☐ Yes 2 X No Specif	an, Puerto Rican, etc.)		Race - Americ Black, White, cify: Wh		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.	than "natu he Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(Give I life. D	ent's Usual Occupation aind of work done during mo O NOT use retired) istered Nurse	ost of working		of Business In alth Car	_	
and 2 be filed wintal Hygie	sed other sevent, t	m l	17. Father's Name (First, Middle, Last) Vilas Defiette		T. T.C.S	18. Mot	ther's Name (First, Middle Margaret Mahor		name)		
Maryla 12 should the alth and Me	27 is mark r traumatio		19a. Informant's Name/Relationship (Type John Bell (Son)	pe, Print)		ng Address (Street and Num Gaither Street	ber or Rural Route Numb	er, City or Tov		Code)	
more, Page 1 and nent of Hea	ant: If item ıry or othe		20a. Method of Disposition 1	Removal from State	cemetery, crer	sition (Name of natory or other place) Cemetery	Date 9-13-2011		ion - City or T	own, State	
Balti permit. Departr	Importa any inju once.		21. Signature of Funeral Service License	mordel	F	Name and Address of Fac	ton, MD 20735		c 6633 (Old Alexandria	
Physi	ician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition	lications that caused the deat e cause on each line.		er the mode of dying, such a	as cardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	edical miner		resulting in death) Sequentially list conditions,	Due to (or as a conseq	uence of):						
nted	ansit	Examiner	if any, leading to immediate cause. Enter Inderlyin. Cause (Disease or linjury that initiated events	Due to (or as a conseq							
760 cate be executed	I physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a conseq	uence of):						
ision of Vital Records, P.O. Box 687(Attending Physician. The law requires that the death certifica er death.	been signed by the attending pl should be detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of g Unknown	al death 3	Ectopic pregnancy Other (specify)		230	d. Date of deli	very Day Year	
s, P.O.	signed by Id be detac	þ	Part II. Other significant conditions co	ontributing to death but not re	sulting in the	underlying cause given in Pa				the cause of death?	
of Vital Records, ag Physician: The law requires	has le 2	Completed					per	s an 2 opsy formed? s 2 \$\sum_No	prior to c death?	opsy findings available ompletion of cause of	
Vital	s certific director,	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 🎞 No	Hospital: 1 ☐ Inpatient 2 ☐	BR/Outpatie	Other	eath (Check only one) Nursing Home 5 X Res	sidence 6	Other (Speci	fy)	
on of nding Phath.	After th funeral	Certificate;	27. Manner of Death 1 Patural 5 Pending 2 Accident Investigation		28b. Time of injury	f 28c. Injury at work? M 1 \sum Yes 2	28d. Describe	how injury o	ccurred		
Division tal or Attendings after death.	To the Funeral Director; completed filled in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special		reet, factory, office	28f. Location City or To	(Street and Nown, State)	lumber or Rur	al Route Number,	
the Hospital	ne Funera pleted fill	Medical	(Chock 2 Medical Evami	sician: To the best of my knowner: On the basis of examination of rectioner: To the best of r	on and/or inve	stigation, in my opinion, death	n occurred at the time, date	e and place, ar the cause(s) a	nd due to the o nd manner as	stated.	
To th	To to		29b. Signature and title of certifier William	lune h		29c. License numbe			signed (Month		
BBI	15		30. Name and address of person who	empleted cause of death (Ite	m 23a) (Type, Mn	D3520 11701 Wings	m Rook Fa	L WAS	Hoph	Juny/m2	
F	Sta Registi		31. Date filed (Month, Day, Year)	20 32. Registrar's Sign	ature A.	grand !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:15 A Joan K. Belt Sept 8 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year May 11, 1931 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1 🗆 M 2 🗶 F Months Hours **Director** 578 40 3115 80 Yrs. Washington DC Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 ☐ Yes 2 🛣 No Forestville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2600 Kirkland Ave United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2XX No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 ₩ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th Auditor Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William . Blakenev Ruth Prettyman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth A. Anthony (Niece) 6705 Woodland Road, Morningside, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lee Crematory Clinton, MD 9-10-2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 100122 Ferry Road, Clinton, MD 20735 Flat 1. Enter the disease, or complications that sa sed the eath. Do not enter the mode of dying speck, or heart failure. List only one cause on vach line. Immediate Cause (Final Priysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Year 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ 28a. Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No Accident
Suicide
Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only, one 29b. Sign ture and tipe of certifier 29c. 29d. Date signed (Month, Day, Year) death (Item 23a) (Type Print) Name and address of person who comp

State Registrar 32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Arcenious W. Bean 125am Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Plat If Under Age (In vrs. last birthday 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, June 29 **X** M 2 □ F Month Hours Min 577 48 3790 92 Yrs. Maryland **Director** 1919 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖵 No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10815 Brookwood Ave 20772 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XXNo 1 Never Married 2 Married Black, White, etc. δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farming 7th Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arcenious W. Bean, Sr. Jane Louise Tolson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor A. Bean (Wife) 10815 Brookwood Ave, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 9-13-2011 4 ☐ Donation 5 ☐ Other (Specify) Forestville, MD Epiphany Episcopal Church Cemetery re of Funeral Service License moisss 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MERKELL Physician/ CELL CAHLER METASTATIC Medical resulting in death) Due to (or as a consequence of) Examiner Due to (or as a consequence of). NEUMOAIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury SPIRATORY FAILHRE ACUTE Hospital or Attending Physician: The law requires that the death certificate be executed Exam burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ped 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🗆 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient_3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 Pes 2 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 00 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day

HMDCIVIST

32. Registjar's Signature

Garrett Ave La Plata MD 20646

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 29928 11-06647 Steven Allen Bryant 1- For State Certificate of Death Registrar Reg. No Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day September 3, 2011 **Medical Examiner** 1155 hrs Steven Allen Bryant 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4500 Crain Hwy Prince George's Rowie If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Foreign Months Hours Director 407-80-5225 56 Country)Kentucky 1 XM 2 F 07/12/1955 Vre Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c City Town or Location 1 X Yes 2 No or 28a-f show ΚY Washington Springfield Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

aof: If item 27 is marked other than "natural", or items 23a or 28a-f she is other traumatic event, the Medical Examiner must be marified at non-Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 40069 205 Amory Hill Rd. USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 No If Yas, Give Year White 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify: Vietna m ₫ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Laborer Farming 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James Henry Bryant Eula Mae Flatt 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Common Ramona Lynn Kulin Springfield, KY 205 Amory Hill Rd., aw-wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 XCremation 3 Removal from State Department (9/9/2011 Crematory Baltimore, MD Donation 5 Other Specify: Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., 20715 Bowie, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line een Onset and /Medical Death a Mixed drug (Methadone and Diazepam) and Alcohol Intoxication Immediate Cause (Final disease) xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Ducito (or as a consequence of). (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, per me, $g_{919} = 9-23-11$ sm X UNPENDED attending physician or use as the burial Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown icate has been signed by the att page 2 should be detached for Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No the Hospital or Atteoding Physician: thin 24 hours after death. the Fuoeral Director: After this certifi mpletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 Yes 27. Manner of Death 28a. Date of Injury 28d Describe how injury occurred subject ingested methadone, Diazepam and Alcohol 28b. Time of Injury 28c. Injury at Work? 1 Natural fd 9-3-11 5 Pending 1 Yes 2 X No fd 11:15 am

Division of Vital

2 X Accident

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

3

4

Medical

State

30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 31. Date filed (Month P

(Specify)

and manner stated

Investigation

Could not be

determined

1ª4 201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

Bowie, Md.

28f. Location (Street and Number or Rural Route Number, City or Town, State)4500 Crain Hgwy.

September 4, 2011

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc

Mote1

gistrar's Signature

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ BISHOP AUDREY Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Howard Ellicott City Encore at Turf Valley 9. Birthplace (State or Foreign Country) Missouri If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Hours 84 Director 494-24-3046 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Heatt streems 23a or 28a-f show that if item 27 is marked other than "natural", or items 23a or 28a-f sho iny or other traumatic event, the Medical Examinar must be notified at jury or other traumatic event, the Medical Examinar must be notified at 10b. County Director 1 Tes 2 X No Anne Arundel Harwood Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 144 Three Rivers Rd. 20776 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 X No þ 1 ☐ Never Married 2 🏋 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) |Federal Government Administrative Assistant 12th 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Stella Hager Louis Reily 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 144 Three Rivers Rd., Harwood, MD 20776 Frank M. Bishop/ Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🏋 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crownsville, MD MD Veterans Cemetery 8/31/11 21. Signatu Fyheral Service Unsee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phylician/ months BRAIN disease or condition resulting in death) Medical Examiner Sequentially list conditions, Due to (or as a consequence of) any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) 1 Live Birth 2 Fetal death 4 Pregnant at time of death Month Dav Year in the past 12 months? 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩Known 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 🗆 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Natural Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier certifying physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causes) and manner stated.

Cartherro News Fredions 1, 1919, and my provided 3 of the purpose of the causes and due to the causes and manner as stated. and due to the cause's and manner as stated. U Certifying Nurse Fractioner: To the best of my knowledge. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) AUG 31

9650

32. Redistrar's Signature

21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State RegistramEND#23bperMD,9/9/11; EMW, MbCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18:04 PM Physician/ Medical own, or Location of Death 4a. Facility Name (if not institution, 4c. County of Death Examiner 9. Birthplace (State or Foreign **Funeral** Country) New York 1 🗓 M 2 □ F Months 132-34-4836 66 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f sho with the Maryland Funeral Director ms 23a or 28a-f s must be notified 1

Yes 2 □ No Baltimore City Maruland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 U.S.A. 2314 E. Fairmount Avenue permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify Caucasian "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) **5**+ Elementary/Seconday (0-12) Government Consultant Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) ပ Betty Aronsky Harry Bender 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10090 Mill Run Circle, #142F, Owings Mills, MD 21117 Health a tem 27 is Merrill Bender - Daughter Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of 1 X Burial 2 Cremation 3 Removal from State Olney, Maryland Judean Memorial Grdns 09/05/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Service Licensee MISLOY 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancrest Cancer Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate the burial-transit Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death signed by the a 1 Yes 24 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use ontribute to the cause of death? 1 Tyes 2 No. 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: မ MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man r of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred **✓** Natural work? 5 Pending thin 24 hours after death the Funeral Director: A mpleted filled in by the fi Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one) 29b. Signature and title of certifier 90 RES-000 WP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Hill

2011

06

3. Registrar's Signature

TIECENCE
31. Date filed (Month, Day, Year)

SEP

600 N. WOLFE St., BAltimORE, MD QIAS,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:50 AM 2011 A. Bergholz August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline 17985 Marvel Road Marydel 9. Birthplace (State or Foreign Country) New Jersey If Under 24 Hrs. 8. Date of Birth (Month, Day, July 21 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours ^{Year)} 1945 1 □ M 2 🕅 F 66 Yrs 146-34-5175 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Event and once. 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director Maryland | Caroline Marydel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17985 Marvel Road 21649 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Saltimore, Maryland 21215-0036 Specify δ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) restaurant waitress 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Walter F. King Catherine Haynes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17985 Marvel Road; Marydel, Maryland 21649 Dennis Bergholz/ 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Xurial 2 ☐ Cremation 3 ☐ Removal from State Aug 26, 2011 Clarksboro, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) Eglington Cemetery 22. Name and Address of Facility Box 160; Greensboro, MD 21639 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home, PA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischemic cardiomyobathy Year Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) burial Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performe 1 ☐ Yes 2 ☒No this certificate 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2. ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

VAIDYANATHAN 219 S. WASHINGTON ST, CASTON

Registrar's Signature

2011

2160

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Lakshm Vardyanathan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AS 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pauline Virginia Bovey 20/1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HICOM 100 PENINSULA SALISBUN REGIONAL Social Security Numb If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 🏝 F Min. Hours 387-26-4213 0373071927 Virginia Director 84 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Worcester Ocean Pines Maryland 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral USA 21811 1135 Ocean Parkway, Bldg, 3, Unit 313 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bertie Ray Berlegh Carl Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1135 Ocean Pkwy, Bldg 3, Unit 313, Ocean Pines, MD 19a. Informant's Name/Relationship (Type, Print) Don V. Bovey/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 K Cremation 3 Removal from State 8/31/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Ph. sician/ ANTERIOR MYU LARDIAL LUTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Soquer tially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 Yes 2 🗌 No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 🗌 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

10

30. Name and address of pers

E.

Shore

n who completed cause of death (Item 23a) (Type, Print)

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virgie Veronica Brown 11:00 A M Sept. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cheverly 4c. County of Death \mathbf{PG} **Examiner** PG Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 02-28-1919 Wash. DC 1 🗆 M 2 💢 F 577-48-6795 92 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director PG Mitchellville MD 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with the USA Funeral 11821 Decesaris Blvd. 20721 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ral", or iter Examiner à 1 Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Private 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental Fitem 27 is marked o other traumatic eve ဂ Frances Sparrow Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 11821 Decesaris Blvd. Mitchellville, MD 20721 Eugene A. Brown/Son other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 9-08-2011 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRonald Taylor_II FH 21. Signature of Funeral Service Licenses 10583 Middleport Ln. White Plains, MD 20695 -Krowa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ Hypercapnic Respiratory Failure Medical resulting in death) Due to (or as a consequence of) Examiner Aspiration Pneumonitis/Sersis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last Upper G.I. Bleeding/Vomiting as the burial-tran the attending physician hed for use as the buria Massive Cerebrovascular Accident To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 month 1 Yes 2X No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Seizures 1 Yes 2 No 3 XProbably 4 Unknown 24b. Were autopsy findings available Diabetes Mellitus 24a. Was an prior to completion of cause of death? performed? 1 Yes 2 X No Hypertension 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No ☐ Accident Investigation 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and tille of certified wavegungun, Uzo MA 29d. Date signed (Month, Day, Year) 0068038 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar WADGWUGWU

31. Date filed (Month, Day, Year)
SEP 0 7 2011

420AmAlcA

3001 Hospital Dr. Cheverly, MD 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 29934 Certificate of Death Reg. Nor 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHN LEE BONNER SEPTEMBER Day 2011 11:04 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S 324 COLUMBIA LANE STEVENSVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 ★M 2 ☐ F Funeral Months Days Hours Min MISSOURI **Director** 491-26-3709 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location notified at Director 28a-f 1 Yes 2X No MD QUEEN ANNE'S STEVENSVILLE 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 324 COLUMBIA LANE 21666 UNITED STATES items Page 1 and 2 should be filed within 72 hours after death "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian rmed Forces?
X Yes 2 No 1950-Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 1953 al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry CHIEFONOT US CONTROLLED OF PUBLIC EMPLOYEE LABOR RELATIONS College (1-4 or 5+) Elementary/Seconday (0-12) DEPARTMENT OF LABOR 12 5+ Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည OTIS JOHN BONNER HELEN McLAUREN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANA BONNER / WIFE 324 COLUMBIA LANE, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE CREMATION 09/02/2011 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Concer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendian account. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Month Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

only one) 29b. Signature and title of certifie

30. Name and address of

son who completed cause of death (Item 23a) (Type, Print)

istrar's Signature

60

29c. License number

St It floor

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2011 **Physician** Sept. 7:10 РМ 1 Rosalie Evelyn Bailey /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Cambridge Mallard Bay Center 8. Date of Birth (Month, Day, Year)
March 10,1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F Pennsylvania 90 178-36-4424 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Nedical Exerting must be notified at 1 □Yes 2 No Director Maryland Dorchester Hurlock 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21643 4508 James Andrews Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify. White þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, II a Madie once. Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Sales Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Irene Corl Wray Adolphus Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4508 James Andrews Road, Hurlock, MD 21643 Shirley Bailey/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 9/2/2011 Delmar, Delaware Crematory Of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Si in ture of Furieral Service Lic Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD END 21631 Part / Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, streck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBROYASCULAR Immediate Cause (Final ACLIDENT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner GASTRO INTESTINAL BLEEDING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) physician a Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) ☐Yes 2 NoNo the 9 Unknown 9 ☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4₽ Nursing Home 5 Residence 6 Other (Specify) မ After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier MD D69234 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21613. CAMBRIDGE MD BYRN JEEVAN ERRABOLU STREET 503 31. Date filed (Month, Day, Year, 32 Registrar's Signatur State SEP 0 6 2011 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records.

Hospital or Attending Physician: The

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra 9/9/11 amended #9 ekt Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August James De Brighton 31 Day $2011^{\rm ear}$ 9:15 p. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5856 Richardson Road Cambridge Dorchester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 X M 2 D F Months Days Hours April 11 Director 138-14-6654 90 New York Jerse Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at or items 23a or 28a-f show 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5856 Richardson Road 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. Maryland 21215-0036 þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates.1940-81 Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) 12 U. S. Marine Corps test pilot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Brighton Lulu Taylor ige 1 and 2 should but of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris A. Brighton wife 5856 Richardson Road, Cambridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State injury or permit. Page Department of Important: If any injury or Crematory of Delmarva 9/3/11 4 Donation 5 Other (Specify) Delmar, DE are of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Cambridge, MD 21613 700 Locust St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Oriset and Death Physician/ carcinon disease or condition resulting in death) 110x Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) ending physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery atter 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ò in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Unknowr signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed certificate 1 ☐ Yes 2 ☐ No. Yes 2 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 Tyes 2 Ne 은 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi, 29c. License number D31766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21613 Mary Ann D. Moore, M.D. 300 Dorchester Ave., Cambridge, MD

State Registrar 31. Date filed (Month: Day, Year

32. Re

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
Amend 23a per med cert G 19 9723/11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar 29937 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Bowen-Saynder 5 Epsie 1:0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2X□ F Jamaica. 043-26-7680 90 5-4-1921 West Indies Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Baltimore Parkville 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 7905 Ardmore Avenue 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify. SperMack 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse's Aide Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Williams Eva Duncan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie Burkett/Daughter 7905 Ardmore Ave, Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-27-2011 Darien, CT Spring Grove Cem Pennie Smith W. Isabella St. 21. Signature of Funer Survice License Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure Respiratori disease or condition resulting in death) hour s Due to (or as a conse uence of): Status Epilepticus/Meningioma Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence or; Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Tectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

/Medical

Physician

/Medical

10a. State

Director MD

Funeral

\$

Completed

Be

ည

Examine

Physician/Medical

þ

Completed

Be ည

Certification:

Medical

29b. Signature and title of stiffier

31. Date filed (Month, Phy Gea 2 3

IF FEMALE:

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notifled at

the Medical

item 2

permit. Page Department o Important: If i any Injury or once. = 5

Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physician Examiner

use as the burial-transit The law requires that the death certificate be executed

be detached for

page 2 should

certificate

this

after death 5

filled in by the funeral

Box 68760. <u>6</u> Attending Physician;

Division of Vital Records,

e Funeral I Hospital completely To the I within 2 To the I

State Registrar

Other signi	neant conditions c	ontributing to death but not re	suiting in the underlyin	g cause given in Part i.	_		se contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☒ Unknown
					-	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referr	red to medical			26. Place of D	eath (C	heck only one)	
examiner? 1 \(\text{Yes} \) 2	No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐ I	OOA Other: 4 - Nursing	Home	5 Residence 6	□ Other (Specify)
27. Manner of Deat 1 X Natural 2 ☐ Accident	h 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d	I. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Speci		ory, office	28f.	Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier (check only one)		ysician: To the best of my kno niner: On the basis of examina and manner stated.					and manner as stated. place, and due to the cause(s)

29c. License number

RES -000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marica Lemmas wo

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year) (8tr

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For state Registrar #19a, per fh, 09/07/11, ca Certificate of Death Reg. No. 2. Date of Death 3. Time of Death September 5 2011 **Physician** Vernon Gale Cooper /Medical 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Princess Anne Manor Somerse Manokin B. Date of Birth (Month, Day, Ye. June 13, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours Wisconsin 1 ₩ 2 □ F 215-38-9183 81 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show ral", or Items 23a or 28a-f show 1 ☐Yes 2 ⊋No **Funeral Director** Md. Somerset Princess Anne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21853 United States 30198 John Somers Rd. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Nol 961
If Yes, Give Year or Dates: 1968 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) h and Mental Hygiene.
7 Is marked other than "natur traumatic event, Its Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U. S. Coast Guard Chief Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vern Cooper Amy Kolstadt Cooper ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bonnie Bonnie Stone t: If item 27 Is PO, Box 144, Princess Anne, Daughter Md. 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If i any Injury or once. Beechwood Cemetery 09-08-2011 Princess Anne, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signatur of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, Md. 21853 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impediate Cause (Final disease or condition resulting in death) **Physician** 5 years /Medical Due to (or as a consequence of): Examiner EMPHYSEMA 5 yravs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending 24 hours after death, Funeral Director: A investigation 1 ☐ Yes 2 ☐ No filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Nah September 6 15 2011 XLA DOS 1359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 . S. DIVISION ST. SALISBURY MD 21804 NATES AN. DR. USHA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **SEP 07** Registrar Beneva

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #9 per IVR G919 9/23/11 dk. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** JOSEPH **DOUGLAS** CROCKETT 3, 6:40 P September 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner McCready Memorial Hospital Crisfield Somerset If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 € M 2 □ F Months Days Hours Maryland 215-58-5154 60 Director 03/05/1951 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Mudical Exeminer must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Maryland Somerset Crisfield 1y Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Cove Street 21817 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2X Married 1 ∐Yes 21X No Specify: Specify:White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dock Worker Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Crockett ဥ Julia Pruitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Crockett (Wife) <u> 19 Cove Street - Crisfield, MD 21817</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State Crematory of Delmarva 09/06/2011 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE 21. Signature Funcial Service Licensee

Robert H. Bradshaw, Jr. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiovascula Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner) abutes Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 **X** No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∑Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 certificate has been signed by the rector, page 2 should be detached : After this certific funeral director, n 24 hours after death.

Reference of prector: A pletely filled in by the fu completely

Baltimore, Maryland 21215-0036

within 2 To the

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, PrintRobert Klug, M.D.

32. Registrar's Signature

201

Hall

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0004

29c. License number

29d. Date signed (Month, Day, Year)

MD

State

30. Name

OC

Year)

0 6 2011

nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryland State of Maryland		artment of He tificate of De			iene 0 1 1	29941
Physicia Medic		1. Decedent's Name (First, Middle, Last) Martha Anne Connorton				2. Date of Deat		3. Time of Death 4:30 PM
Examin		4a. Facility Name (if not institution, give street and number) 7080 Cradle Rock Way, #603	3	4b. City, Town, or L			4c. County of Dea	th
Funeral Director		5. Social Security Number 219–05–3786 6. Sex 1 □ M 2 🕱 F 92	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/24/1	9. Bi Year) 9. Bi 918 Mar	rthplace (State or Foreign ountry)
/land f show ed at	tor		Town or Loc					10d. Inside City Limits
the Man a or 28a- be notifie	I Direc	Maryland Howard 10e. Street and Number	COTI	umbia 10f. Zip Code		1	0g. Citizen of What C	1 \(\sum \) Yes 2 \(\beta \)No buntry?
eath with tems 23 er must	Funeral Director	7080 Cradle Rock Way, #603 11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hisp	panic Origin? (Spe	cify Yes or No-	U.S.A	
0036 urs after c ural", or i	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed *4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates.		Yes, specify Cuban,		Rican, etc.)	Black, White Specify: Wh	
Iryland 21215-0036 Juld be filed within 72 hours after death with the Maryland of Mental Hygiene. Marked other than "patural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed	(Specity only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k life. DC	ent's Usual Occupat kind of work done du D NOT use retired)	ion ring most of worki	ing	16b. Kind of Business	Industry
and 2. e filed with tal Hygie ed other: event, th	ou l	8 17. Father's Name (First, Middle, Last) Archelaus A. Hastings	Homen		18. Mother's Name		At Home	
Maryland 2 should be filed v th and Mental Hyg 7 is marked othe traumatic event,			19b. Mailin	g Address (Street an	d Number or Rura	Route Number,	City or Town, State, Z	
_ ~ ~ ~ ~ ~		20a. Method of Disposition 20b. Plac	e of Dispos	Clear Smo			20c. Location - City or	Town, State
Baltimore, sermit, Page 1 and Department of Hea mportant: If item any injury or othe		4 Donation 5 Other (Specify) 21. Signature (Specify) Reho		Baptist (Rehobeth	, MD
T 80 = 8 8	-	Robert H. Bradshaw, Jr. 23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.		Name and Address & Adshaw & Address & Adshaw & Address &				Approximate
Physician/ Medical	9	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequent of the cause o	ce of):	Demen	ntic_			Interval Between Onset and Death
Examiner	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequent						
be executed sician and burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last C	ce of):					
icate be e	ledical	d						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	eath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
us, F.C.	2	Part II. Other significant conditions contributing to death but not resulti	ng in the un	nderlying cause giver	n in Part I.		acco use contribute to	o the cause of death? Probably 4 \(\square\) Unknown
DIVISION OT VICAL RECORDS, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Completed					24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
VICAL IN hysician: The his certificate I director, pa	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER	/Outpatient	Other	e of Death (Check		nce 6 Other (Spec	cify)
ending Pt eath. or: After th	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident ☐ Investigation	b. Time of injury	28c. Injury a work? M 1 ☐ Ye	t 2 es 2 🗆 No	28d. Describe hov	w injury occurred	
rital or Attendinus after death.		4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)				City or Town,		
the Hosp hin 24 hou the Funer npleted fill	Med	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge only one) 2 Medical Examiner on the basis of examination are only one) 3 Certifying Nurse ractioner: To the best of my knowledge on the basis of examination are only one)	d/or investig	gation, in my opinion	death occurred at	the time date and	nlace and due to the	cause(s) and manner stated
5 A With		29b. Signature and title of Certifier		29c. License n	umber.		Date signed (Mont	
15		30. Name and address of person who completed cause of death (Item 23	a) (Type, Pr	int) (ave	Colu	bia V	1 yes 3	civ
State Registra		31. Date filed (Month, Day, Year) SEP 01 2011 32. Registrar's Signature	b. A	bace				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2011 Donald W. Collins 24 8:14 P August Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Wicomico Nursing Home cial Security Number 6. Sex, Salisbury 9. Birthplace (State or Foreign Country) Maryland Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** Days Min. Months Hours 03-13-1935 215-30-4510 76 **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important, If item 27 is anarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Salisbury Md. Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4786 Dividing Rd. 21801 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
Yes 2 . No þ 1 Never Married 2 Married UNKNOWN Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates. Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 08 College (1-4 or 5+) Construction Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Robert Edward Collins Mary Wheeler Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21801 Dean Murray-Stepbrother 4786 Dividing Rd. Salisbury, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Salem U.Meth. Cemetery 08-31-201 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State Pocomoke, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hinman Funeral Home 21. Signature of Funeral Service Licensee M00295 21853 1673 Somerset Ave. Princess Anne. 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b, Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 Yes 2 No Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗆 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

pho

DHMH 17 Rev 7/2009

910 Easternshore Dr Salisbury

MD

21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Mahesha Thimmarayappa M.D.

31. Date filed (Month, Day, Year)

Henry Nicklas Caya Section Se		Ple	ease Type or Pr				•	•	ile.
Providing Prov			State of M	•			•	001	
Henry Nicklas Caya Reminded Modelan Reminder M		Registrar	dle. Last)	(Certificate of I	Death		1000	3. Time of Death
Excitation of Least Post Post Post Post Post Post Post Po				a					
Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Socia							1	,	
213-20-3016 Top-Order To	Funeral	5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birtho	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th 9). Birthplace (State or Foreign
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final			1 X M 2 L F	35 Y	rs.	TIOUIS IVIIII.	106-03-	1926 W	Washington, DC
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final	-f shov ed at ctor		•	,					10d. Inside City Limits
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final	or 28a e notifi Dire		er c	SOTOROL				10g. Citizen of Wha	1 ☐ Yes 2 💢 No
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final	is 23a and the transit be	13449 Stowawa	y Court						
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final	or item niner n		Armed Forces?		 Was Decedent of H If Yes, specify Cubi 	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- po Rican, etc.)	14. Race Black, \	
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final	urs afte		ed If Yes, Give 1 Year or Dates.	944-1947	1 ☐ Yes 2 💢 No	Specify:		Specify:	White
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final	in "nat Medica mple	(Specify only high	hest grade completed)		Give kind of work done	during most of work	king	16b. Kind of Busin	ness Industry
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final	withir giene rer the t, the Co		College (1-4 or	Fac	cility Dire	ctor		Electron	ics
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final	Id be filed Mental Hy larked oth atic event								
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final	12 shou ulth and 27 is m r traum		1 1 21 /						
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final	age 1 and ent of Hez nt: If item ry or othe		n 3 Removal from State	20b. Place of I	Disposition (Name of crematory or other pla	ce)	Date	20c. Location - Cit	ty or Town, State
Physician/ Medical Examiner 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (Final Introduced cause) (Final	ermit. F				22. Name and Addre	ess of Facility	Rausch	Funeral	Home, P. A.
Physician Medical Examiner Part Medical Examiner Medical Examin	Q □ = Ø Ø	23a. Part 1. Enter the disease,	or complications that cause	d the death. Do no					Approximate
Part II. Other specific part of general transport of the part II. The	Physician/	Immediate Cause (Final	t only one cause on each lin	STATE	Canco	27			Interval Between Onset and Death
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a		resulting in death)	Due to (or as	a consequence of				-	
FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 5 Other (specify) 23d. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was and autospoy for prior to complete death of Death (Check only one) 24d. Was and autospoy for prior to complete death of Death (Check only one) 24d. Was and autospoy fo	iner	I if any, leading to immediate		a consequence of):				
FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 5 Other (specify) 23d. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of delivery Month Day Pregnant at time of death 5 Other (specify) 23c. Date of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was an autospoy for prior to complete death of Death (Check only one) 24d. Was and autospoy for prior to complete death of Death (Check only one) 24d. Was and autospoy for prior to complete death of Death (Check only one) 24d. Was and autospoy fo	and I-transi	Cause (Disease or linjury that initiated events		a consequence of);				
30. Name and address of person who completed cause of death (Item/ISa) (Type/Print) State 31. Date filed (Month Jay, Year) 32. Registrate Signature	(a) Fig. (b)		d	,	·				
30. Name and address of person who completed cause of death (Item/ISa) (Type/Print) State 31. Date filed (Month Jay, Year) 32. Registrate Signature	ding ph se as th		23c. If yes outcome	of pregnancy					
30. Name and address of person who completed cause of death (Item/ISa) (Type/Print) State 31. Date filed (Month Jay, Year) 32. Registrate Signature	eath ce e attend d for us	in the past 12 months?	1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal death		су			
30. Name and address of person who completed cause of death (Item/ISa) (Type/Print) State 31. Date filed (Month Jay, Year) 32. Registrate Signature	at the d d by the etache			out not refulting in	the underlying cause of	ven in Part I	230 Did to	obacco use contribu	ito to the cause of death?
30. Name and address of person who completed cause of death (Item/ISa) (Type/Print) State 31. Date filed (Month Jay, Year) 32. Registrate Signature	uires that signed ald be d	apprela	artery	diser	200)				
30. Name and address of person who completed cause of death (Item/ISa) (Type/Print) State 31. Date filed (Month Jay, Year) 32. Registrate Signature	aw requas beer 2 shou	hoerte	notion						re autopsy findings available or to completion of cause of
30. Name and address of person who completed cause of death (Item/ISa) (Type/Print) State 31. Date filed (Month Jay, Year) 32. Registrate Signature	icate h	05.111	. , , , , ,				perfo 1 ☐ Yes		ith?
30. Name and address of person who completed cause of death (Item/ISa) (Type/Print) State 31. Date filed (Month Jay, Year) 32. Registrate Signature	s certif	examiner?	Hospital:	iont 2 \square EB/Outr	_ Oth	er.		dense 6 🗆 Other //	Propify)
30. Name and address of person who completed cause of death (Item/ISa) (Type/Print) State 31. Date filed (Month Jay, Year) 32. Registrate Signature	nding Phy tth.: After this s funeral c	27. Manner of Death	28a. Date of inju (Month, Da	ıry 28b. Tir	me of 28c. Injur	y at k?	1		specify)
30. Name and address of person who completed cause of death (Item/ISa) (Type/Print) State 31. Date filed (Month Jay, Year) 32. Registrate Signature	I or Atter after des Director d in by th	3 Suicide 6 Coul-	d not be 28e. Place of Inj	ury - At home, farn c. (Spec <i>ify</i>)	n, street, factory, office				r Rural Route Number,
30. Name and address of person who completed cause of death (Item/ISa) (Type/Print) State 31. Date filed (Month Jay, Year) 32. Registrate Signature	Hospita 24 hours Funeral leted filled	(Check 2 <u>☐ Medical</u>	Examiner: On the basis of e	examination and/or i	investigation, in my opini	on, death occurred a	at the time, date a	and place, and due to	the cause(s) and manner state
State 31. Date filed (Month Jak, Year) 32. Registrate Signature	To the within To the comp			Is a second			and dde to the		
State 31. Date filed (Month Jak, Year) 32. Registrate Signature),	Grice	ORTANIA	0	DOO.	47/3	7	Scotemi	ter 2,2011
	W 10+1	Eric Gera, n	10 HOST	Hall Al	125 (C) 310	Parco	Frell	rickim	n 206 78
DEF TO MILL DENKER D. Backet	State Registrar		P − 6 2011 ≥ 2	ans Signature	8. Sale	0	. , - , 000		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		2011 29	944
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	nog. reg.	e of Death
	Physicia		Karl Brown Clifford		Month Day Year	36P M
	Medic Examin	-	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		-
	LAGITIE	CI	406 South Main St.	Berlin	Worcester	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (Sta (Month, Pay, Year) Country)	
	Director		298-14-0832	Michael Suye History	8/25/1925 Country) O	H
	nd how at	'n	10a. State 10b. County 10c. City, Town or Lo	cation	10d. Insid	e City Limits
	faryla 8a-f s iified	Director	MD Worcester Berlin	ו	1 🛭	Yes 2 ☐ No
	the N		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
	n with	Funeral	406 South Main St.	21811	USA	
	death r item iner n		Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - American Indian Black, White, etc.	١,
36	al", o	Completed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:	Specify: white	
9	hours natur lical E	lete	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business Industry	
Maryland 21215-0036	e. han "	삡	Elementary/Seconday (0-12) College (1-4 or 5+)	kind of work done during most of work O NOT use retired)		
2	d with lygien ther th	o l	4 Teacl		Education	
anc	should be filed within 72 n and Mental Hygiene. 7 is marked other than " raumatic event, the Mec	일	17. Father's Name (First, Middle, Last) William L. Clifford		ne (First, Middle, Maiden Surname) 1. Brown	
Ž	ould the mark				al Route Number, City or Town, State, Zip Code)	
Š	12sh alth ar 27is rtrau			ay St., Berlin,		
Jre,	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)	Date 20c. Location - City or Town, Stat	е
<u><u> </u></u>	Page ment cant li		4 Donation 5 Other (Specify) OH Weste	ern Reserve 9/8	/2011 Rittman, OH	
Baltimore,	permit. Page 1 a Department of I Important: If its any injury or ot				rbage Funeral Home , Berlin, MD 21811	
			23a. Part 1. Inter the disease, or complications that caused the death. Do not ent		or respiratory arrest, Approx	imate Between
	hysician/	2 U	Immediate Cause (Final disease or condition	AR ASEMSE		and Death
عر	Medical Examiner		resulting in death) Due to (or as a consequence of):			
		ē	Sequentially list conditions, b. Due to for a 2 nemecularizer;	W.		
	ed nsit	Examiner	Sequentially list conditions, if a y, load get immediate cause. Enter Underlying Cause (Disease or linjury			
	ate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
09	e be e iysicia ie bur	dical	d			
876	tificat ng ph as th	Med	IF FEMALE:			
× 6	eath certifica attending ph	ian/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day	Year
P.O. Box 687	r the a	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown			
0.	requires that the der been signed by the s should be detached	y PF	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause	of death?
JS,	puires en sign	ed b			1 Yes 2 No 3 Probably	Unknown
Sor	law req has bee je 2 sho	Completed by			24a. Was an autopsy findi autopsy prior to completion	ngs available of cause of
Rec	The Is ate ha	Con			performed? death? 1 Yes 2 No 1 Yes 2 No)
tal	ician: sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)	<u>v</u>
Ž	Physic this cral dir	욘	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a, Date of injury 28b. Time of	nt 3 □ DOA 4 □ Nursing H	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred	
o u	ding th. After fune	cate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 Yes 2 No	Zod. Bossinge flow injury document	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route N City or Town, State)	lumber,
Ω	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, a	nd due to the cause(s) and manner as stated.	
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check only are) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s) an	d manner stated.
	To the Total		29b Signature and true of certifier	29c. License number	29d. Date signed (Month, Day, Yea	7
			Chumee 3	046257	4././/	*
	ET 01	,	30. Name and address of person who completed cause of death (Item 23a) (Type, Edwin Castaneda 10324 Old Ocea	n City Blvd Be	rlin MD 21811	
E	Stat	te	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	-		
	Registra		SEP 0 6 2011	na Kad		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 08 2011 Physician/ Dorothy Elizabeth Colson 10:35 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Columbia Howard 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours Country) 1 M 2 F 1071971938 72 **Director** 218-32-8178 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director 1 X Yes 2 No Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 640 Matterhorn Road 21158 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces Black White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Sales Random House Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ J. Norman Brown Margaret C. Wantz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Jeffrey Colson, son 640 Matterhorn Road, Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important; If ite any injury or otl 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗀 Donation 5 🗆 Other (Specify) Evergreen Mem. Garden 09/01/2011 Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Road, Westminster, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENTIFICATION ROPROVED BY MEDICAL EN Physician/ QUENST 18,2011 Richt disease or condition Medical resulting in death) **Examiner** GUST 18,2011 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit HEPATIC ENCEPHALDPATH MONTHS Due to (or as a consequence of): resulting in death) Last Physician/Medical Adepocarcinoma of DistalCommon Bile Duct MONTHS P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work?
1 Yes Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Slip and FALL 2 Accident Investigation 0100AM August 18, 2011 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 2, 7, City or Town, State) Suicide 4 Homicide determined NURSING HOME Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number WJL

WJL 5

DHMH 17 Rev 7/2009

State

Registrar

6336 CedAR LANE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATHRYN BIACKFORD

AUG 31

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEN DITEM#5perFH, 6925,3/7/2012, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 5:45a M August Thomas P. Crowley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Bowie 2507 Kennet Lane 233-56-9841 235-50-5841 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV • 8, 1937 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Country) Ohio Months 73 Director Nov. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MDPrince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö er than "natural", or items 23a of the Medical Examiner must be Funeral U.S.A. 20715 2507 Kennet Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 XYes 2 No Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 1959 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Wash DC Dept. of and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Engineer</u> Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ other traumatic Thomas Edward Crowley Antholine Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is Iris J. Crowley - Wife 2507 Kennet Lane, Bowie, MD 20715 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ Department of Important: If any injury or once, Metro Crematory 9-1-2011 Baltimore, MD Donation 5 D Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final SCHEMIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of the attending physician and the for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tyes ΙNο 24a. Was an 24b. Were autopsy findings available To the Hospital or Anna.
within 24 hours after death.

To the Funeral Director, After this certificate has the Annaleted filled in by the funeral director, page 2. prior to completion of cause of death? autopsy performe 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Cartifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and marrier as status 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 116 Deforse Huy #400 STEPHEN C. HOMILTON MD 31. Date filed (Month, Day, Year) AUG 3 1 2011 Registrar

11-06403 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joyce B. Corsanico 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day August 25, 2011 **Medical Examiner** 1243 hrs Joyce B. Corsanico 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 9402 Coastal Highway Ocean City Worcester 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 6. Sex **Funeral** oreign Country) PA Months Day Hours Director 180-42-9388 54 10/13/1956 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits Iny 10b. County 10c. City, Town or Location 1 Yes 2 No or items 23a or 28a-f show mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28a-7 sho Montgomery Blue Bell Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1337 Cernan Lane 19422 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black 11. Marital Status 12 Was Decedent Ever in U.S. White, etc. 1 Never Married 2 X Married Armed Forces? 2 X No Yes White If Yes, Give Year 1 Yes 2 No specify: 4 Divorced Specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** 12 Administrative Assistant Pharmaceutical 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Milton Knappick Anna Harbach ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas P. Corsanico 1337 Cernan Lane, Blue Bell, PA 19422 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 X Removal from State √illiam Penn Cemetery 8/30/2011 Philadelphia, PA 4 Donation 5 Other Specify. 22. Name and Address of Facility George P. Kalas Funeral Home eral Service Licensee 2973 Solomons Island Rd., Edgewater, Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line. /Medical Death a. Subarachnoid Hemorrhage Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical attending physician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? و 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been si 24a. Was an 24b. Were autopsy findings available autopsy performed? death? Yes 2 No funeral director, page 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 ✔ Other: Scene 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c, Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification 1 V Natural Pending 1 Yes 2 No filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year AUG 3 Registrar

Laron Locke MD.

146

30. Name and address of person who completed cause of death (Item 23a)

1 2011

ORIGINAL

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

August 26, 2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ², Katherine September 2011 12:15 pM Frances Cappelletti Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Friends Nursing Home Sandy Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 M 2 XF Hours May 18, Country) 213-46-8098 96 Director D.C. Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified MD Brookeville 1 Yes 2 No Montgomery 10e. Street and Numbe ō 10f Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 19011 Dellabrooke Farm Way 20833 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc ò þ 1 Never Married 2 Married 1 Yes 2**X** No Specify. White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 ₺ Widowed 4 □ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F 7 is marked o and of Health and tem 27 is mark. ည Giovanni Cataldi Lucia Battaglini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOhn Cappelletti/Son 6314 Tulsa Lane, Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State P cemetery, crematory or other place) Sept. 2011 Department of Important: If any injury or once. Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Vicenses Francis des Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph sician/ Myocardial Infarction Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death detached the ģ s been signed to should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hemorrhagic Shock 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has page 2 autopsy performed' 1 Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes Other: 읻 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 IER/Outpatient 3 I funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director, After in 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, September 2, 2011 039793 eted cause of death (Item 23a) (Type, Print) Christopher J. Mays, MD 18111 Prince Philip Drive, Olney, MD 20832 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State 0 6 2011 Registrar

rawfrd, Bernice

Physician/ Month 8 Bernice Marion Crawford Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dice Sbu ru d. Sex If Under 1 Year If Under 24 His 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 1 M 2 X F Days 219-28-4482 Hours Yrs b8/28/1933 Director 78 Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location Director notified 28a-f Maryland Caroline Denton 10e. Street and Number 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? with Funeral 529 N. 6th Street 21629 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 K Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical onc. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Clerical MVA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Zaharko Vernon Bartosz 19a. Informant's Name/Relationship (Type, Print)
Wayne Homens/Son o Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6425 Abel St., Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 🗆 Other (Specify) 8/31/2011 Anatomy Gifts Registry Hanover, MD Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or commecations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ercbro disease or condition resulting in death) Resides Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami burial-transi and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Box 68760 the attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death the 9 Unknown Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 XNo Completed 1 🗌 Yes page 2 should 24a. Was an has autopsy performed? Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my antique death. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 0262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY MD

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

DICOMICO

Mary land

14. Race - American Indian, Black, White, etc.

White

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Month

Dav

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 🗌 Yes

Year

1 🗌 Yes 2 🗶 No

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ sept 201°1 1:05 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot The Pines Easton Genesis HealthCare 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Country) MD 1 M 2 □ F Days Hours Min 012198 **Director** or 28a-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event,, the Medical Examiner must be notified at 10a. State 10d, Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: HITE Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Ph sician/ respiratory Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dementiaque to Alchemers, history or 1 Yes 2 No 3 Probably 4 Unknown T, and MI, hx non Hodgkins Lymphoma 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autoosy death? 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard

Easton

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lorenia Faye Clark August 2.8 2011 8:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. Oct 111, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 X F 95 Yrs. T915 Tennessee Director 408-36-3070 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notined at 1 ☐ Yes 2X No Director Maryland Queen Anne Marydel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Duhamel Corner Road 21649 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rote ပ Barnes Lula Jane Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Hinkle/ granddaughter 108 Duhamel Corner Road; Marydel, Maryland 21649 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park Sept 1 201 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licenses 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION seconds /Medical **Examiner** UROMANY ANTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? res 2 L page 1 🗌 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation after death.
I Director: A 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

State Registrar

Helen Noble 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

122 Speer Road Ste 5

Back.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number
D 0041587

Chestertown MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rema F. Carter 26 2011 1313 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 110MIO SALISBUM TENINSULA REGIONAL If Under 1 Year If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🏿 F Months Days 217-07-1616 94 07/08/1917 **Director** Maryland Usual Residence of Deceden 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State 10d, Inside City Limits Director 1X Yes 2 ☐ No Wicomico Maryland Salisbury 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 300 South Haven 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3

Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Clothing Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Virgil H. Foskey Minnie Serman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31448 Spearin Rd., Salisbury, MD 21804 Lionel Carter/son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 8/29/2011 Salisbury, MD 21. Signature of Funeral Service License TowayFineFally Ho Snow Hill Rd., 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final hip tractive Physician/ disease or condition resulting in death) dous Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician as Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 X Yes 2 □ No Other: <u>۾</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident work? iniurv 5 Pending 2 🗶 No trip and (all 1300 8/22/2011 Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 300 S. Haven Ave. Salishury home 24 hours a Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying urse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 6 only one) 29b. Signature ar nd title of o 29c. License numbe 29d. Date signed (Month, Day, Year) HO05936 8 8/29/11

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address/of persor

31. Date filed (Month, Day, Year,

Visich

AUG 3 1 2011

ted cause of death (Item 23a) (Type, Print)

E. Carre

100

HT049)

8/29/11

21801

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.0.

of Vital

HOSPITA

Laurel Regional

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Baako,

Michael

31. Date filed (Month, Day, Year,

7300 Van Dusen Road

MD

		A	me	Pleas nd #25, per ME g	of Jype or Prin	t in Bl	ack In	delible	e Ink	. Ens	ure All (Copies	s Are	e Legi	ble.		•
			-	For State Registrar	State of Ma	rylariu	Cert	ificate	of D	eath	aria ivior		Reg. No	/ 1 1 7		299	54
				Decedent's Name (First, Middle, L.)	ast)							Date of Dea			Year	3. Time of E	
		Physicia Medic	al	MAURICE VINCEN	r cecil							Month PT.	1	20.		8:00	A M
1	,,,,,,,	Examin	er	4a. Facility Name (if not institution, g				4b. City, To		Location o				. County of QUEE!		NE'S	
	- Sand	Francis		416 ROLLING BR		(In yrs. last	birthday)	If Under 1		If Under	24 Hrs. 8. I	Date of Bir	th		9. Birth	olace (State or	Foreign
		Funeral Director		215-36-0288	4 V M 2 D E	72	Yrs.	Months	Days	Hours	Min. NO	Month, Da	y, Year)	38	MAI	YLAND	
		d ow t	L	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loc	ation							- 1	10d, Inside City	Limits
		arylan a-f sh fied a	Director		ANNE'S			EVILLE	E							1 🗆 Yes	2 🔀 No
		or 28	Dire	10e. Street and Number				10f. Zip 0	Code				10g. C	itizen of W	/hat Cou	ntry?	
		with s 23a ust b	Funeral	416 ROLLING BR	IDGE ROAD				2161					USA			
		death item: ner m		11. Marital Status	12. Was Decedent Ev Armed Forces?		13. W	as Deceder Yes, specif	nt of His y Cubar	spanic Ori n, Mexicar	gin? (Specify n, Puerto Rica	Yes or No- n, etc.)			e - Americ k, White,	ean Indian, etc.	
	36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Marrie 3 👿 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🗶 N If Yes, Give Year or Dates,	10	1	☐ Yes 2	X No	Specify:				Specify:	WH:	(TE	
	9	hours natura lical E	lete	15. Decedent	s Education	17	16a. Deced	ent's Usual	Occupa	ation	t of working		16b.	Kind of Bu	siness In	dustry	
	121	/ithin 72 iene. r than " the Mec	Completed	(Specify only highest Elementary/Seconday (0-12)	College (1-4 or 5+	+)	ìife. DC	OREMA	retired)	uning mos	e or we rning			EEN A			
	and 2	ntal Hyg ed othe event,	To Be	17. Father's Name (First, Middle, Last	•						er's Name (Fir)		
	Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-1 show item 27 is marked other than "natural", or items 25a or 28a-1 show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship AMY PAJULA/ DAU	(Type, Print)		19b. Mailin 2468	g Address (Street a	nd Numbe	er or Rural Ro	ute Numbe	er, City o	or Town, Si	tate, Zip	Code)	
	altimore,	Page 1 and ment of Heal ant: If item 2 ury or other		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Sp		cem	netery, crem	sition (Name eatory or oth	her place	red V	SEPT. 2011		l .	Location -		own, State	
	Baltir	permit. Page 1 a Department of H Important: If ite any injury or otl		21. Signoture Inc. Pervice Lic		,						NEWN	IAM I	FUNER	AL E	IOME, P 21617	.A.
				23a. Part 1. Enter the disease, or c	omplications that caused	the death. I										Approximate Interval Bety)
		[®] nysician/		shock, or heart failure. List on Immediate Cause (Final disease or condition	y one cause on each line.	IDD	EN	D	E	477	+ 1					Onset and D	
		Medical Examiner		resulting in death)	Due to (or as a						ΛI		\wedge				
		sit sit	Examiner	Sequentially list conditions, if any, leading to immediate bause. Linter Unidenying Cause (Disease or linjury	b. Due to (or as a	consequer	nce of):			/	1//	$\overline{}$	A2100	EXAMINE	.R	-	
		cate be executed physician and s the burial-transit	_	that initiated events resulting in death) Last	c. Due to (or as a	consequer	nce of):			CER	TIFICATIONAP	PROVED BY	MEDION				
ME	9	ate be Inysici the bu	dica	•	d					- CLI					_		
*	68760	ertifica ding p se as t	/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome of	of pregnanc	y _				7			23d. Da	te of deli	very	
H	Box	death c the atten	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown	2 ∐ Fetal d time of dea	death 3 Lath 5 C	Ectopic pa Other (spe	regnanc ecify)	;y 				Мо	nth	Day Y	'ear
3	P.O.	at the		Part II. Other significant condition	s contributing to death bu	ut not result	ing in the u	nderlying ca	ause giv	en in Part	ıl.	23e. Did	tobaccc	use conti	ribute to	the cause of de	eath?
7	S, F	uires ti sign	q p	HYPER	etensto	N C						1 🗆	Yes	2 No	3 🗆 Pr	obably 4 🗌 I	Jnknown
	oro	w requ	Completed by	ORTI	TO STATE	C 1	HYP	OTE	NS	TO		24a. Was	s an opsy	- 1 - 1	prior to c	opsy findings a ompletion of c	vailable ause of
	Rec	The la ate ha page ?	l E									perf	formed?	No	death? 1 🔲 Yes	2 🛐 No	·
	E	sician: The law r certificate has t irector, page 2 s	Be (25, Was case referred to medical examiner?	Hospital:						ath (Check on	ly one)					_
	Ž	Physic this o	은	1 X Yes 2 11 No	1 Inpatie		R/Outpatier 8b. Time of		Othe Bc. Injury	4 ⊔ N	lursing Home	5 Pescribe				fy)	
	D 0	ding f h. After funer	cate	1 Natural 5 Pending 2 Accident Investiga	(Month, Day		injury	M Z	work		1	, Describe	HOW HIJ	ary occurr			
	Division of Vital Records,	al or Attending Phy s after death. I Director: After this d in by the funeral d	Certificate;	3 Suicide 6 Could n 4 Homicide determin	ot be 28e Place of Inju		e, farm, stre	eet, factory,	office		28f	Location City or To			er or Rur	al Route Numb	er,
		To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Chook 2 Medical Ev	Physician: To the best of examiner: On the basis of examiner: On the basis of examiner To the	ramination a	and/or invest	tigation in m	nv opinic	on death o	accurred at the	time, date	and pla	ce, and du	e to the c	:ause(s) and ma	nner stated.
		To the vithing to the composite of the c	2	29b. Signature and title of certifier	1	/		29c.	License	e number				Date signe		, Day, Year)	
		12/42			Cop xuet				23	56	>4 8	>		91	1/	1.7	
		(), E.	1	30. Name and address of person w ERIC F. CIGAN	ho completed cause of d	eath (Item 2	:3a) (Type, F FT.R∩AT	Print) AVF	NITE	CEN	TREVII.	LE. M	D 2	1617			
		Sta	to.	31. Date filed (Month, Day, Year)	22 Livietro	ar's Signatur	M A	AVE	/	JIM		,					
		Registr		SEP - 6	2011 Janes	1	- 7										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29955 1 - State Registrar Amend # 26 perphysician 9/12/11c Carbificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept 5, Physician/ Joseph J. Diana 9:30 P 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's 40120 Beach Road Mechanicsville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Di Day, Year, 1917 1 XX 2 F Months Days Hours New York **Director** 053 07 7552 94 Aug Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Prince George's Camp Springs 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4509 Keppler Place 20748 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify: White Completed 3XX Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Int'l Monetary Fund permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other 1 any injury or other traumatic event, th Photographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lillie Volo Calogero Diana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina M. Diana (Daughter) 1210 Colonial Pk Drive, Severn, MD 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery | Sept 12, 2011 Clinton, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MOIS55 Ferry Road, Clinton, MD 20735 23a. Part/l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** -ud 5/2 Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events Exami The law requires that the death certificate be executed and tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ed by the a Yes 2 No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available 24a, Was an page 2 prior to completion of cause of death? autopsy performed certificate 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? M Other (Specify) daugther residence Hospita. 2 **S** No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 **X**in 4 Nursing Home Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 2011 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 139 M9 21401

State

31. Date filed (Month

strar's Signature

Bresch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Ma	aryland / Depa	artment of H	lealth and N	/lental Hyg	iene 011	29956
		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	<i>Jeatn</i>	2. Date of Deat	eg. No.	3. Time of Death
Physici Medi		John William Douglas, Sr.					28, 2011 Year	3:39 PM
Exami		4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Cente	r	4b. City, Town, or Annapol			4c. County of Dea	
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth	9. Bi	rthplace (State or Foreign
Director		224–52–6371 1 M 2 🗆 F Usual Residence of Decedent	98 Yrs.	Months Days	Hours Will.	May 24	, 1913 Ke	entucky
rland Fshow dat	tor	10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits
e Man r 28a-i notifie	Director	MD Anne Arundel	Crofto	1 10f. Zip Code			l 0g. Citizen of What C	1 Yes 2 XNo
with th s 23a o ust be	Funeral	1749 Scribner Place		21114			USA	ountry :
death ritems nerm		11. Marital Status 12. Was Decedent E Armed Forces?	: I:	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	Completed by	1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates.	W W II 1	☐ Yes 2 🔀 No	Specify:		Specify:	White
15-0	plet	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupa kind of work done d		ing	16b. Kind of Business	s Industry
within giene.		Elementary/Seconday (0-12) College (1-4 or 5-	+)	O NOT use retired) enant Co	mmander		U.S. Navy	
land be filed vental Hygerked otheric event,	To Be	17. Father's Name (First, Middle, Last)	<u> </u>		18. Mother's Nam	•	faiden Surname)	
Aaryla should be and Meni s marke raumatic	٦	John William Douglas 19a. Informant's Name/Relationship (Type, Print)	405 14 77	(2)		ldham M	eek City or Town, State, Z	Un Contact
d 2 sho d 2 sho alth an 27 is or trau		Les E. Douglas / Son		g Address (Street a 54 Park <i>P</i>		randywin		613
Jore, ge 1 and it of Heal if item		20a. Method of Disposition 1 By Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	UNK	Date	20c. Location - City o	r Town, State
T James Lag		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee		Nat'l Ce		Beall Fr	Arlington, neral Hom	
Balti permit. Departr Importa any inju		21. Signature of Parisaria Service Character		5512 NW	,		owie, MD	20715
		23a. Part 1. Enter the disease, or complications that caused shock, or head failure. List only one cause on each line	the death. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	consequence of):	al unf	ucteo	<u>~</u>		Onset and Death
Examiner		Due to to as	consequence oi).	/				
d sit	Examiner	cause. Enter Underlying	consequence of):					
be executed sician and burial-transi	Exar	Cause (Disease or linjury that initiated events c. — Due to (or as a possible of the control of	consequence of):					
760 ate be executed physician and the burial-transit	dical	d						
certificate nding physuse as the	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	of pregnancy				OOJ Data of J	- Union
ords, P.O. Box 687 requires that the death certificate been signed by the attending particular be detached for use as it.	Physician/Me	in the past 12 months? 1 Live Birth Pregnant at	2 🗌 Fetal death 3 🗌	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	Day Year
at the class that the class the etache	Phys	g ☐ Unknown Part II. Other significant conditions contributing to death bu	it not resulting in the u	nderlying cause give	en in Part I	22a Did tob	pacco use contribute t	to the cause of death?
ords, P.O. requires that the been signed by the	d by			g cause giv				Probably 4 Unknown
VItal Kecords, ysician: The law requires is certificate has been sig	Completed					24a. Was ar		utopsy findings available completion of cause of
He la cate ha page						perform	ned? death?	
/ital sician certifi	To Be	25. Was case referred to medical examiner? 1 Yes No Hospital:	ent 2 ER/Outpatien	Othe	r: Chec		C	- 15 d
Of \ ng Phy fler this meral c		27. Manner of Death Natural 5 Pending (Month, Day,	y 28b. Time of	28c. Injury	at		ence 6 Other (Spe w injury occurred	Cny)
SION ttendii death. stor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ry - At home, farm, stre	1	Yes 2 □ No	Oof Leasties Of	reet and Number or R	unal Pourte Alumbar
DIVISION OT tal or Attending Pr rs after death. al Director: After th ed in by the funeral		4 Homicide determined 206. Place of Injul	(Specify)	set, factory, office		City or Town		urai noute Number,
Division of Vital Reco To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier Certifying Physician: To the best of r	amination and/or invest	igation, in my opinio	n, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated.
To the within 3 To the сотрlе	Σ	only one 3	pest of my knowledge, c	29c. License	number		-	s stated. h, Day, Year)
		+ Jygot OVlaver no	7	D/4	376		8730/	//
741041		30 Name and address of person who completed cause of de	eath (Item 23a) (Type, P	cal Pa	Revar.	Amar	olis MD	2 1401
Sta		31. Date filed (Month, Day, Year) AUG 3 1 2011 32. Registral	r's Signature	cal Pa	/	7		<u> </u>
Registr	aı	TOU O I LOTT	m 14. 14	www				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29957 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nicholas J. DiPietro 2011 2:30 P M August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Queen Anne's Hospice of Queen Anne's Centreville If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 89 Washington, DC Director 577-22-9611 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho.
ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Shore Drive 21037 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 ₩ Widowed 4 □ Divorced Year or Dates. W.W. II White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Pipe Fitter/ Supervisor Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Bellafatto Fiorvante DiPietro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. DiPietro/ Son 816 Monroe Manor Rd., Stevensville, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 9/2/11 Resurrection Cemetery Clinton, MD 22. Name and Address of Facility George F. Kalas Funeral Home 21. Signatur 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final set and Death Ph_sician/ me 10 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Caose (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 🗌 Yes been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to autops performed Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 2 **X** No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 Nursing Home 5 Residence 6 X Other (Specify 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Center injury 5 Pending work? Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated f death (Item 23a) (Type, Print)

2 2 2 Name and addr who completed cause Defense Hwy. Crofton, MD mo av re2

Registrar

31. Date filed (Month

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29958 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Francis Michael Dabrowski September 8. Medical 2011 6:25 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7435 Casey Avenue Easton Talbot 6. Sex 1 **X** M 2 □ F Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours May II, 1933 Director 186-24-4784 78 Pennsylvania Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits Maryland Talbot Easton 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7435 Casey Avenue 21601 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc. "natural", or 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Whi<u>te</u> Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 land Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 H.S. Grad, College (1-4 or 5+) Engineer Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Chester Miercrzcyslaw Dabrowski Mary Jancrycka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Barbara Ann Dabrowski 7435 Casey Avenue Easton, Maryland Baltimore, 20a. Method of Disposition
1
Burial 2
Cremation 3
Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 4 Donation 5 Other (Specify) Capitol Crematory Sept. 9, 2011 Dover. Delaware Swature Funeral Service Licensee 22. Name and Address of Facility Moore Funeral Home, P.A. LOCA 12 South Second Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ATHOSCIEKO Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury A and that initiated events resulting in death) Last Due to (or as a consequence of) burialbeen signed by the attending physician should be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant for L 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending Accident Investigation 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

C-OX

204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wilkerson

10el H.

D0027055

9-8-11

P.O Box 100 Grasonville Md. 21638

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29959 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2011 Physician/ Month Marv J. Edmunds 28 Medical 11:45 p^M Aug 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brinton Woods Health Care Sykesville Carroll Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 217-01-8229 Months Days Hours Min. 7/5/ 1917 Director 94 Usual Residence of Decedent or items 23a or 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at by Funeral Director 10c. City, Town or Location 10d. Inside City Limits MD Carroll Hampstead 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4323 White Oak Court 21074 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 XNo If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: 'natural", 3 ₩ Widowed 4 □ Divorced Completed Specifyhite event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha homemaker 10 own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roddy Kagan Anne (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Kathleen G. Adams, daughter 5489 Vantage Point Rd., Columbia. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salem UM Cemetery 8/31/2011 Hampstead, MD Signature of Funeral Service Licensee 22. Name and Address of Facility ELINE FUNERAL HOME M00741 934 S Main Street Hampstead, MD 23a. Part 1. Enter the disease, or complications that caus. The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Millery disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) and burial-tran resulting in death) Last Due to (or as a consequence of). attending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death Month Day signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) WJL nd address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

HTRICK

AUG 3

31. Date filed (Month,

SUSINCES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charlotte Catherine Eccard September™, 2011 6:30P. Medical 4a. Facility Name (if not institution, give street and number)
Renaissance Cardens at Riderwood Village Examiner 4b. City, Town, or Location of Death 4c. County of Death
Prince George's Silver Spring '. Age (In yrs. la: 91 . Social Security Number 217–12–7423 9. Birthplace (State or Foreign **Funeral** last birthday 8. Date of Birth 1 ☐ M 2 💢 F Months Days Hours March Day, Year 1920 Mary Tand **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a State City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland Prince George's Silver Spring 1 🗆 Yes 2 🔀 No 10f. Zin Code 10g. Citizen of What Country? 3160 Gracefield Road, RC#1331 20904 United States "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 X No Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give White 3 X Widowed 4 Divorced Specify: Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) X-Ray Tech Medical office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental P is marked o ೨ C. Finley Clopper Lydia Virginia Hornbaker 9a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen E. Mellott -daughter 1 and 2 s if Health a item 27 i 11402 Howard Court Beltsville, Maryland 20705 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Mt. Olive U.M. Church Cem. 9/5/2011 4 Donation 5 Other (Specify) Randallstown, Maryland 21. Signature of Funeral Service Licensee DônaldovodeBorgwardt Funeral Home, PA Donald UBa 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Arteriosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Mellitus Type II Sequentially list conditions, Examine any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) attending physicial for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12**y**nonths? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month signed by the a 1 ☐ Yes 2 t 9 ☐ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia - vascular: 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Obstructive Pulmonary Disease autopsy 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) မ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

Registrar

Box 68760

Division of Vital

State

31. Date filed (Month, Day, Year)

SEP 06 2011

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eileen Gemmell, CRNP 3160 Gracefield Road Silver Spring, Maryland 20904

R1586601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER 14 2011 THOMAS WALKER ELIASON. 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 211 David Dr. Chestertown Kent Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 6 9. Birthplace (State or Foreign Funeral 1 № M 2 🗆 F Months Days Hours Maryland 1918 212-28-2014 93 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 □ No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 211 David Dr. 21620 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 X Yes 2 ☐ No 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: WWII 1 ☐Yes 2 No White þ Specify 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) Accountant Self-employed Health and Mental Hygidem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas W. Eliason, Sr. Marquerite Cree 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Eliason (daughter) P.O. Box 357 Chestertown, MD. 21620 other t Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery 9/17/11 Chestertown, MD. 4 ☐ Donation 5 ☐ Other (Specify) of Fun ra Galena Funeral Home of Stephen L. M00510 118 West Cross St. Galena, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate C v se (Final disease or undition resultin in death) **Physician** emol /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to infinied accause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a collisequence of death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of) physician at the burial Physician/Medical nding parase as IF FEMALE nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ed by detach signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2D No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 performe certificate 1 □ Yes 2 1 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 □Other (Specify) After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Box 68760, Ö ۵. Division of Vital Records, or Attending Physiclan:

altimore, Maryland 21215-0036

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew S. Ferguson, M.D.

120 Speer Rd. Chestertown, MD. 21620

Date filed (Month, Day, Year) SEP 2 0 2011

29b. Signature and title of ce

32. Registrar's Signature

and manner stated.

Registrar

D0051786

29d. Date signed (Manth, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	e Type or Pri						_			e.
		For State		State of M	arylar		epartme Certifica			Mental Hy	ygiene Reg. N		29962
Physicia	· · · /	Registrar 1. Decedent's Nam	e (First, Middle, L	.ast)			i 1	ile Oi i	Jeani	2. Date of D	t-		3. Time of Death
Physicia Medic	cal	ALC NO	ard	ive street and number)		FIE				Month		24 2	011 1030 A M
Examin	er	The Jor	ins Ho	OPKins H	050	ita	\ Ba	ty, Town, o Ltimo	r Location of Dear	th	40	c. County of D	eath
Funeral Director		5. Social Security N 215-84-59	umber 6	Sex 7. Ag	e (In <i>yr</i> s	last birtho Yı	day) If Uni	der 1 Year is Days	If Under 24 Hrs Hours Min		irth Jay, Year)	9.	Birthplace (State or Foreign Country)
nd how at	'n	Usual Residence of 10a. State				tv. Town o	or Location				100		10d. Inside City Limits
Maryla 28a-f s otified	Director	MD	Carrol	1		mar							1 ☐ Yes 2X No
vith the 23a or st be n		10e. Street and Nun 7314 Keys		ാമർ		_		Zip Code L 757			10g. C	itizen of What	Country?
items	Funeral	11. Marital Status	74110 10	12. Was Decedent I	ever in U.	S.	13. Was Dec	edent of H	lispanic Origin? (S	pecify Yes or No			merican Indian,
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy righty or other traumatic event, the Medical Examiner must be notified at once.	δ	1 Never Marr		1 Yes Xif Yes, Give Year or Dates.	No				an, Mexican, Puer Specify:	to Rican, etc.)	:	Black, W Specify:	hite, etc. White
72 hou in "nat Medica	Completed			grade completed)		(0	Decedent's Us Give kind of v fe. DO NOT u	vork done	during most of wo	rking	16b. F	Kind of Busine	ss Industry
d within ygiene. her the it, the I	Be Co	Elementary/Sec		College (1-4 or 5	5+)	1 -	reman	ise retired)			Car	roll C	ounty Roads
be filed ental H rked ot ic ever	To B	17. Father's Name (I							18. Mother's Na Betty L	me (First, Middle • Osborr		Surname)	
2 should h and M 7 is mar traumat		19a. Informant's Na							and Number or Ri	ural Route Numb	er, City o		
1 and 3 of Healt item 2 other		Betty L. 20a. Method of Disp	osition		20b. F	Place of D	Disposition (N	ame of	oad, Mano	Date Date		.ocation - City	or Town, State
t. Page tr⊓ent c rtant: If		4 Donation	5 Other (Spe					ı. Gar	rden Aug				
permi Depar Impor any ir		21. Signature of Fu	neral Service Lice	ensee					ss of Facility]				e & Chapel D 21157
		23a. Part 1. Enter t shock, or hear	he disease, or co	mplications that caused one cause on each line	the deat	th. Do not						/CCL / 1.	Approximate Interval Between
Physician/ Medical		Immediate Cause (disease or conditio resulting in death)		a. Due to (or as		uonaa afi							Onset and Death
Examiner	<u>_</u>	Sequentially list co	nditions.	b. ——	a conseq	uence on.							
uted d	Examiner	if any, leading to im cause. Enter Under Cause (Disease or	nmediate riying iinjury	Due to (or as	a conseq	uence of):							
e executed cian and ourial-transit	al Ex	that initiated events resulting in death) I		Due to (or as	a conseq	uence of):	:						
icate be ex g physician is the burial	ledic			d									
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Fuheral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	al death	3 Ectopi 5 Other		су			23d. Date of Month	delivery Day Year
hat the ed by tl detach		g Unknown Part II. Other signif	icant conditions	contributing to death b	ut not res	sulting in t	the underlyin	g cause giv	ven in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
quires t en sign ould be	ted by									1 🗆	Yes 2	X No 3 □	Probably 4 🗌 Unknown
has be	Completed									24a. Was	psy	24b. Were prior death	autopsy findings available to completion of cause of
an: The tificate tor, pag	l o	25. Was case referre	ed to medical			_		26. PI	ace of Death (Che	1 🗌 Yes	ormed? 2 X N		Yes 2 No
hysici this cer al direc	To B	examiner? 1 Yes 2					atient 3 🗌	Othe	er.	Home 5 Res	idence (6 ☐ Other (Sp	pecify)
nding Fath. : After e funera	icate	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending Investigat	28a. Date of inju (Month, Day	ry (, Year)	28b. Tim inju		28c. Injury work 1 🗆		28d. Describe	how injur	y occurred	
al or Atter s after des l Director d in by the	Certificate:	3 Suicide 4 Homicide	6 Could not determine	be 200 Place of lais					100 2 2 10	28f. Location City or To			Rural Route Number,
Hospit 24 hour Funera sted fille	Medical	(Check 2	□ Medical Exa	nysician: To the best of miner: On the basis of each	xaminatio	n and/or ir	nvestigation, i	in my opinia	on death occurred	at the time date	and place	and due to the	ne callee(c) and manner state
Io the within 2 To the comple	Š	only one) 3 29b. Signature and t	☐ Certifying N	urse Practioner: To the	best of m	y knowled	lge, death occ	ourred at the 9c. License	e time, date and pl	ace, and due to t	he cause(s) and manner	as stated. nth, Day, Year)
WIL		Do	- 0	MO					- 000		Aug	gust 24	4, 2011
74		Davis	S:M	completed cause of de 1000 F	C. Fa	grer	St I	ีวาไ+ร่า	ohns Hop more, MD	kins Ho	spita	al	
Stat Registra	e	31. Date filed (Month	AUG 25	2011 32. Registra	ır's Signa	ture	/	~ A	MOTE, MID	21202			
negistra	11			4VIII Alexen	ريس	D.	Mark	-					

DHMH 17 Rev 7/2009

11-06798 Russell Farley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Russell Farley	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.
Physician/ Medical Examiner	Russell Farley September 9, 2011 Year 0142 hrs
	4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center 4b. City, Town, or Location of Death Glen Burnie 4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1
Aaryland 28a-f show any lat once. ector	Usual Residence of Decedent 10a. State
with the Maryland ms 23a or 28a-f sho be notified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1636 Collesbury Place 20794 United States
or ite	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent Ever in U.S. 16. White, etc.
5-0036 led within 72 hours after Hygiene. i other than "natural", the Medical Examiner Completed by	16 December 5 Augustics (Consideration Consideration Consi
	Dale E. Farley Helen Spittler
and and	Dale E. Farley - Father 1636 Colesbury Place, Jessup, MD 20794
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other fraun	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Baltimore, MD
	22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Approximate Interva Between Onset and Death Due to (or as a consequence of): Sequentially list conditions,
0, e be executed saician and burial - transit edical Examiner	if any, leading to immediate cause. Enter Underlying Jouse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. Due to (or as a consequence of): d. d.
60, ate be executed thysician and e burial - transit	W AMENDED 20b, per fh, g919 9-28-11 sm 23a, 27 per me g920 10-13-11 vt IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
Records, P.O. Box 6876(The law requires that the death certificate cate has been signed by the attending physpage 2 should be detached for use as the bompleted by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Yes 2 No 9 Unknown 1 Unknown 1 Unknown
P.O. res that the signed by the detached by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records, ing Physician: The law requires ther this certificate has been signeral director, page 2 should be n: To Be Completed	24a. Was an autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
of Vital Physician: er this certi	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year)
Division o To the Hospital or Attending within 24 hours after death. To the Flueral Director: Aft completely filled in by the fune edical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Specify 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the How within 24 h To the Fun completely	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Me s s	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OGME September 9, 2011
HO	30. Name and address of person who completed gluse of death (flem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State Registrar	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar		State of M	aryland		irtmen <i>tificate</i>			Mental Hy	/giene		1	29964
Physicia Medic		1. Decedent's Name	e (First, Middle, Last,	WAL	1-	1	101	P//	10	2. Date of D	eath Da	ay 31, c	グカ/ /	3. Time of Death
Examin		4a. Facility Name (if	not institution, give s	treet and number)	Hos	o'the	4b. City,	Town, or L	ocation of Dea			c. County of	of Death	
Funeral Director		5. Social Security No. 489-54-6	196	7. Ag	e (In yrs. Id.	st <i>birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under 24 Hr Hours Min		rth 9 , 129	49	9. Birth Cou	nplace (State or Foreign ntry) MO
yland f show ed at	ctor	Usual Residence of 10a. State	Decedent 10b. County			, Town or Loc								10d. Inside City Limits
e Mar r 28a- notifii	Direc	DC 10e. Street and Nun	None		W	ashing								1 _X Yes 2 No
is 23a o	neral I		lvert Stre	et, N.W.			10f. Zip	2000	7		10g. C	U.S.		intry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ied 2X Married	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		lf		ify Cuban	Mexican, Puer	Specify Yes or No rto Rican, etc.)			k, White	ican Indian, , etc. hite
n 72 hou e. an "natu Medical	mplet	(Spe	15. Decedent's Educify only highest grad		54)	16a. Decede (Give ki life, DC		k done du	ion ring most of wo	orking	16b. I	Kind of Bu	siness li	ndustry
l withii ygiene her th t, the				5+	J+)	Home	makeı	:				Owr	1 Ho	me
d be filed Mental Hi arked otl	To Be	17. Father's Name (i	First, Middle, Last) Daniel Wa	:11						ame (First, Middle Lle Faga		Surname))	
2 should hand hand hand transfer transf			ame/Relationship (Typ			l '				ural Route Numb				·
I and 2 f Healt item 2 other		Joseph 20a. Method of Disp	T. Fiorill position	.o/Husban	20b. Pla	ace of Dispos	ition (Nam	e of		., Washi	1			007 Town, State
Page ment o ant: If ant: If ury or			☐ Cremation 3 ☐ F 5 ☐ Other (Specify)			metery, crem e of H			i		1		-	ing, Md.
permit. Departi Import any inj		21. Signature	neral Service License	MO1315	•				of Facility I	DeVol Fu	nera	1. Hon	ne	
	-	23a. Part 1. Enter t	he disease, or compl	cations that caused	d the death.					c or respiratory a		hingt	on,	Approximate
Physician/ Medical		Immediate Cause (disease or condition resulting in death)		RESI	DIRA	1 tory	1	AII	URE					Interval Between Onset and Death
Examiner	<u>.</u>	Sequentially list co	nditions.	Due to (or a	EUM	nonli	A							
nted	Examiner	if any, leading to in cause. Enter Under Cause (Disease or that initiated events	rlying ilnjury	NEL	a conseque 1+RO	PEN	iA							
cate be execute physician and s the burial-	edical Ex	resulting in death) (Due to (or as		ence of):		OlA	stin	SYNDI	C D/N	ر ۽		
ificate ng phy as the		IF FEMALE:					,		77.00	- 414 21	1			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/N	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?	3c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🔲 Fetal	death 3 🗌	Ectopic p Other (sp					23d. Date Mor		very Day Year
uires that the dea	þ	Part II. Other signif	icant conditions cor	tributing to death b	out not resu	Iting in the un	derlying c	ause give	n in Part I.					the cause of death?
The law require ate has been si page 2 should I	Completed							_		_ perf	opsy ormed?	p	rior to c eath?	opsy findings available ompletion of cause of
sian: T ertifica ctor, p	Be C	25. Was case referre	<i>i</i> .	-				26. Plac	e of Death (Ch	1 ∐ Yes eck only one)	2,24	lo] 1		2 🗆 100
Physic this ce al dire	은	1 Yes 2 2	1140			R/Outpatient				Home 5 Res				fy)
Attending Physician: or death. ector: After this certific by the funeral director,	Certificate:	1 Natural 2 Accident	5 Pending Investigation	28a. Date of inju (Month, Day		28b. Time of injury	M 28	Bc. Injury a work? 1 🔲 Y	es 2 🗆 No	28d. Describe	how inju	ry occurre	d 	
ital or Att urs after d ral Directo lled in by t		3 ∐ Suicide 4 ∏ Homicide	6 ☐ Could not be determined	28e. Place of Injubuilding, etc	c. (Specify)					City or To	wn, State	e) 		al Route Number,
To the Hospital or within 24 hours aftu to the Funeral Dir completed filled in	Medical	(Check 2	Certifying Physic Medical Examina Certifying Nurse	er: On the basis of e	xamination	and/or investig	gation, in n	ny opinion	, death occurred	d at the time, date	and place	e, and due	to the c	ause(s) and manner stated.
withi withi		29b. Signature and	tiple of certifier	MD			1	License r		0		-		, Day, Year)
		30. Name and addre	ess of person who co	impleted cause of d	eath (Item 2	23a) (Type, Pr	int)	1/1/	10/1-	SIR	11'	000		81, 2011 ND 21287
Stat	e	31. Date filed (Monti	h, Day, Year)	2. Registra	ar's Signatu	ire .	VV K	I. W	VITE -	M, 19A	1+1M	10KE	, , //	1102120/
Registra		SFE	0 R 2011	12.		heest	1							

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1 - State Registrar

٠	
68760	
387	
-	
. Box	
P.O.	
S,	
ord	
ec	
H H	
Zį:	
of	
ion	

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. Physician/ 12'.38P M Clarence Plutschak Frase 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Memorial Talbot Easton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 □ F Days Hours Min. (Month, Day, Year) 217-36-0044 96 **Director** 1915 Maryland Mar. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dorchester Preston 1 Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 21655 4307 Langrell Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, an "natural", or iter Me Ical Examiner Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2X No If Yes, Give Year or Dates White 1 Yes 2 No Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ernest Frase Hulda Matilda Plutschak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. Mary Lou Frase/Daughter 4307 Langrell Rd., Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/10/11 Preston, Maryland Junior Order Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Michail 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) ocardia minutes Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (g) a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day been signed by the should be detached 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mx CABG, hx aortic valve replacement, diastolic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown dysfunction and CHF, Parkinson's Dementia, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 25. Was case referred to medical examiner? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 2 1140 1 Yes Yes Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 X Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) Dutchmans Lane, Faston 610 State Registrar

Please Type or Print in Black Indelible Ink, Frayre All Copies Are Legible.
Amend 27 per med cert G920k, Frayre All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

B 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ida Belle Feagins Month AUGUST Medical 2011 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death EASTON MIBOI The memorial Hospita 5. Social Security Number Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F (Month, Day, Months Hours Min Year Director 221-24-0753 72 <u>Maryland</u> Usual Residence of Decedent 28a-f shov 10a. State 10b. County aţ 10c. City, Town or Location Director 10d. Inside City Limits must be notified Caroline Federalsburg MD 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4707 Preston Road 21632 United States or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 14. Race - American Indian, Black, White, etc ð 1X Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 er than "natural", c; the Medical Exam If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Maryland Plastics permit. Page 1 and 2 should be filed wift Department of Health and Mental Hygien Important: If item 27 is marked other tany injury or other traumatic event, the Once. 8 Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Elsie Simms Nichols Walter B. Brummell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George E. Brummell/Brother 2914 Fairland Rd., Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Federal Hill Cemetery 09/03/2011 Federalsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom, Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final sician/ Onset and Death Bradycardia disease or condition resulting in death) **Nedical** Due to (or as a consequence Seven Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a printed needle of): sician and burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of):(resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 2 No 1 Yes 2 L 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, or Attending Physician: The law requires Ancmiai Completed Dehydration Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should acute Renal failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Severe malnounchmen 2 🗌 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Hospital Other: မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) 1 Natural injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State

Registrar

Samantha

31. Date filed (Month, Day, Year)

AUG 3 1 2011

アアスの子し

Easton Memorial hospital

digress of person who completed cause of death (Item 23a) (Type, Print) ha Kalakurthy; Easton Me m

Registrar's Signat

D006945

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per med cert G920 10/25/11 dk

State of Maryland Pepart Health and Mental Hygiene

1 - State Amend Item 25 per me, g924,02/15/2015 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year KEVIND. FOREMAN, 2010 2011 . Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Madiewl (Gater University of Marriano BAltimore Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, April 7, 1<u>963</u> 1 X M 2 🗆 F Months Days Hours Country) Maryland Director 215-80-3796 48 Usual Residence of Deceden or 28a-f show e notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1x Yes 2 No Marvland | Wicomico Salisbury ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral USA 21804 307 Princeton Avenue items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner ance. Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Restaurant laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mable A. Truitt Conwell Foreman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Powhattan Blvd., Salisbury, MD 21801 Mable Foreman/mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Springhill Mem. Gdns | 09/01/2011 | Hebron, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21801 JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ NASOPHANYNGENI Carcinoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COMMON CHANGE INJURY 1 Yes 2 No 3 Probably 4 Unknown Records, AdvIMCS LANTINESAL CANCINGERA, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an inasminute vein insure performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier IL. Klanithan , CRNT L155 115 06/24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALLMONEY MAKTIME Klawitten. 22 South Crisquistnest 21201 CRNP 31. Date filed (Month, Day, Year) State 201 AHG Registrar

 ψ

240

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

			1 - State of Maryland / Del	partment of Health and N ertificate of Death	nental Hygie Reg.	2011	29968
			Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Rosert Giaquinto			2011	1331 M
The second	Examin		4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederic		4c. County of Death Calver	t
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 577–44–1769 1AXM 2 F 84 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ya Jan 20,	9. Birth Cou Wash	place (State or Foreign htry) ington DC
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation			Od. Inside City Limits
	Maryla -f sho	to		ashington			1 ∐ Yes 2 📉 No
	or 28a	Director	10e. Street and Number	10f. Zip Code		. Citizen of What Cou	ntry?
	23a c	ral	10304 Roland Lane	20744		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is if edical Evertinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ J ∨ s 2 □ No If ∀es, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 XXVo Specify: 	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
5-0	72 ho natur	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of work	tina 16t	b. Kind of Business/Ir	dustry
121	vithin sne. than "	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired) umber		Federal (Government
	illed in Hygid	Be Cc	12 F 2 17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	iden Surname)	
/lan	should be fi and Mental H s marked ot sumatic ever	70 B	Attilio Giaquinto	Martha	Christs	en	
Maryland	2 sho n and risma raum			iling Address (Street and Number or Ru			20732
d)	1 and 2 Health tem 27 i			B Dogwood Road, Che		c. Location - City or T	
ē E	Pages ient of nt: If il		1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Resurre	position (Name of rematory or other place) September 1 September 200	$\begin{bmatrix} 10, \\ \end{bmatrix}$	Clinton, M	D
Baltimore,	permit. Pages 1 Department of I Important: If Ite any injury or ot once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 3 8200 Jennifer Lane			lvert, P.A.
			23a. Part 1. Enter the disease, of complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition				Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				do
t.		ē.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):				3042
	ocuted nd ransit	Examiner	that initiated events	nowe!			days
60,	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):				
	ficate physics from the l	edical	d				
Вох	death certific attending p	Physician/Me	In the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli	very Day Year
P.O.	at the de by the tached	hysi	1 Yes 2 No 9 Unknown				
Records, I	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the Shocks liver, acute resulting	underlying cause given in Part I.		cco use contribute to	
eco	e law re has be le 2 sho	Completed			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
al B	r: The licate ha	Con			performe	d? death?	2 🗆 No
Vital	nysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner? Hospital:	Othor	th (Check only one)		
	ding Phy. h. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	ome 5 ☐ Residence 28d. Describe how	ce 6 ☐ Other (Specinjury occurred	ify)
ion	ending sath. or: Aft he fun	atio	1 X Natural 5 Pending (Month, Day, Year) Injur 2 Accident investigation	M 1 □Yes 2 □ No			
Division	ial or Attendi s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, did not be the set	eath occurred at the time, date and place r investigation, in my opinion, death occu	e, and due to the cau rred at the time, date	use(s) and manner as e and place, and due	stated. to the cause(s)
	To t Vith Com	Z	29b. Signature and title of certifier	29c. License number		d. Date signed (Month	, Day, Year)
			TE COM MO	00061783	•	7/4/20	
2	IRW 10		30. Name and address & person who completed cause of death (Item 23a) (Tyr.	ped PRINCE FRED	lerick.	MD 206	78
	Sta Registr		31. Date filed (Month, Day, Year) SEP - 6 2011 According Signature	pad Prince Frequences.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

per fh State of Maryland / Department of Health and Mental Hygiene State 9/7/2011 AACO HEALTH DEPT. Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Chalmers Grant, Jr. 7:05 AM Medical 2911 August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Severna Park Sunrise Senior Living Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Feb. 15, 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F 88 . 1<u>923</u> Massachusetts Director 024-16-6315 Yrs Usual Residence of Decedent Department of Health and Mantal Hygiene.
Important: If item 27 is marked other than "material". 10b. County Director 10c. City, Town or Location MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral IISA 21146 210 Oak Avenue 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 1 þ 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 Divorced Specify Completed WW II 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Joseph E. Seagrams Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပင William Chalmers Grant, Sr. Alice Bentley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Oak Avenue Severna Park, MD 21146 Judy Christie / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-01-2011 Springwood Cemetery Greenville, SC Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, P.A. Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMENHA Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Years Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and the burial-transit Cause (Disease or ii that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P'O. Box 68760 attending philor use as the IF FEMALE: 23h. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 28e. Did tobacco use contribute to the cause of death? 2 Ny Rocki Piller K 1 - Yes 2 No 3 - Probably 4 - Unknown HYPERTENSION, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? Yes 2 Line 1 Tyes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hin 24 hours af the Funeral Di npleted filled ir Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 3868 2011 30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) STEPITEN MYO SEVERNA PARK, MO 2114 6 31 ROBINSON EUAD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 27 2011 ear 09:12 Avhlee M. Grinder Medical 4a. Facility Name (if not institution, give street and number) ^{4c. County of Death} Prince George's Examiner 4b. City, Town, or Location of Death Camp Springs 6211 Trueman Drive 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1073171927 Washington.DC Director 577-30-0088 83 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director be notified 1 Yes 2 No Camp Springs Maryland Prince George's 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral 20748 United States 6211 Trueman Drive ıral", or items 2 I Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give "natural", 3 X Widowed 4 Divorced White Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. 12 Self Employed Glass Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) item 27 is marked other traumatic ev 2 Robert Hulvey Katie Matheny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
94 Two Rivers Drive, Edgewater, Maryland 21037 Diane Grinder/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State - i - i 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Important: It any injury or Kalas Crematory 9/2/11 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 210 Service Licensee 21. Signatur MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be eximiting 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Other (specify) Pregnant at time of death g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural iniury work?
1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

DHMH 17 Rev 7/2009

Lila Mojdeh Bahadori, 10301 Georgia Avenue, #304, Silver Spring, Maryland 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 3 1 2011

D47928

August 29, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #25, PII persue gold of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** August 2011 8:01 PM Rebecca Saulsbury Griffith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Manor Chestertown Kent | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Sept 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Maryland Director 215-26-4114 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24136 Marblehead Road 21660 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White <u>چ</u> Specify: 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene." Important: If item 27 is marked other than "any Injury or other traumatic event, Ihe Masonce. Elementary/Secondary (0-12) College (1-4or 5+) book keeper agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irwin T. Saulsbury Renee Beaziere 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Jarrell/ executor PO Box 600; Denton, Maryland 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State Chesapeake Cremation | Sept 1 2011 | Stevensville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home, PA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a CONGESTIVE HEART FAILURE Immediate Cause (Final Physician weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MULTIPLE INFECTIONS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine LITON APPROVED BY MEDICAL EXAMINER requires that the death certificate be executed TRANS VERSE MYELITIS physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ed by the a Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, been signe should be o Completed by QUADRIPLEGIA due to high cervical lesion 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Vital 2 No 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Xes 2010 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To of After thi funeral 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28a. Date of Injury (Month, Day, Year) Division 5 Pending investigation ours fter death.

neral Director Af
filled in by the fu 1 ☐Yes 2 ☐No 3 ☐ Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours To the Funeral completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State

Registrar

Speer Road Ste 5 Chestertown MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Helen Noble
31. Date filed (Month, Day, Year)

AUG 3 1 2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND ITEM#2perCRNP, G920, 1075/2011, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death August 26, 2011 3. Time of Death 1. Decedent's Name (First, Middle, Last) 145PM Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Ha If Under 1 ear If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 14 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 97 Months 1 M 2 X Aug. 230-22-6313 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c, City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a, State Director 1 ☐ Yes 2 🄀 No MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral U.S.A. 21742 14014 Marsh Pike 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. If Yes, Give Year or Dates Black. 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturing Janitorial unknown 18, Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ္ Mittie Jennings Anthony Oliver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19600 Granada Lane, Hagerstown, MD 21742 Mark Guy/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🌠 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/8/2011 Hagerstown, MD Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Sign In of Funeral Service Licen 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy Month Year in the past 12 months? Other (specify) 2 X No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tes Mellitus T 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: injury 5 Pending 1 X Natural 1 Yes 2 No Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie (Item 23a) (Type, Print) State Registrar

1-06265		Please Ty	pe or Print ir	Black Ir	ndelible	Ink. E	Ensure	All Copi	ies Are I	_egib	le.🤈 🕦 🍴	- 1	29973
Carla Denise G	reen	S	tate of Maryla	ind / Depa	artment d	of Hea	ilth and	Mental I	Hygiene		201	1	2))
		1- For State Registrar		Ce	rtificate d	of Dea	th			Reg. N	0.		
Physici Medical Exam		1. Decedent's Name (First, Midd Carla D. Gr		-				-	2. Date of Month August	Day	Year	3.	Time of Death 0324 hrs
a de la companya de l	.*	4a. Facility Name (if not institution, give street and number) Penninsula Regional Medical Center 4b. City, Town, or Location of Deal Salisbury								•	4c. County of Death Wicomico		
Funeral	7	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Und	der 1 Year	If Under 24H	rs. 8. Date o	f Birth(MI	M/DD/YYYY)		lace (State or
Director		216-90-3628	1 M 2 F	40	Y	Mont	ths Days	Hours M		-197		Foreign Count	try)MD
		Usual Residence of Decedent		10					10 0		·		
v any		10a. State 10b. County	,	10c. City	, Town or Loca	ation							0d. Inside City Limits
and show	ō	MD Wico	mico	Sal	isbur	У							Yes 2 No
Maryl 28a-	rect	10e. Street and Number				10f. Zi	p Code		10g. C	itizen of What	Country	/?	
15-0036 filed within 72 hours after death with the Maryland I Hygiene. sd other than "natural", or items 23a or 28a-f sho t, the Medical Framiner must be notified at once.	ral Director	115 Miami Av	enue				21801				A		
th wit	Pera	11. Marital Status 1 X Never Married 2 N		edent Ever in U rces?				anic Origin? (: Mexican, Puer			14. Race - / White, e		n Indian, Black,
er dea	Fune		1 Yes 2 X No				1 Yes 2 No specify:				SpecifyB1	Rlack	
rs aft ural" ming	by	3 Widowed 4 Di 15. Decedent's Education (Spe	or Dates:		16a. Decede			n (Give kind or	f work done	16b	. Kind of Busin		
2 hou	etec	Elementary/Secondary (0-12)						OO NOT use re					•
5-0036 led within 72 Hygiene. other than *	Completed	12			Cash	ier				M	lovie	Kin	ıq
5-0 led wi Hygie other		17. Father's Name (First, Middle	e, Last)		. L		18	.Mother's Nan	ne (First, Midd				
Ø 5 5 3 5 1	Be	Robert Harp	er					ilvia			2. 182 1	-	
D 2 should and M	٢	19a. Informant's Name/Relation				_	•	and Number or			•		
nore, MD 21; ages I and 2 should be nt of Health and Men nt: If item 27 is mar nther traumatic eve		Robert & Sil	via Harp		Place of Dispo			ne, S	alisbi Date		MD 2 Location - C		
2 S 4 2 2		1 Burial 2 Crematio	n 3 Removal fro	m State	crematory or c	other place	∍)					•	,
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify: Flower Hill Cem 8-30-2011 Eden, MD 21. Signature of Funeral Service Licensee Plower Hill Cem 8-30-2011 Eden, MD 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith 917 W. Isabella St.											
Baltimo permit. Page Department of Important:	1		1 1		B	enni	e Sm	ith 9	17 W.	lsa	petta	5t	1
Physician	9 4	23a. Part I. Enter the disease, o	r complications that ca	used the death	n. Do not enter	the mode	of dying, su	ich as cardiac	or respiratory	arrest, s	hock, or heart	180	Approximate Interval
/Medical	91. Y	failure. List only one cause Immediate Cause (Final disease	on each line.	ication									Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a									\neg	
	Ļ	Sequentially list conditions,	b Due to (or as a		5)							_	
	Ē	if any, leading to immediate cause. Enter Underlying Cause	e of):										
sit d	Examiner	(Disease or injury that initiated events resulting in death) Last											
xecuted n and 1 - transit			d	22- 27	20- £		~0 <i>′</i>	20 10 5	11 ***			\dashv	
O, the ex- sician	Physician/Medical	X UNPENDED		23a,27 27, 28		Perme	g9 23	Y /2771	2 TRT				
68760, certificate be nding physicise as the buri	E	IF FEMALE: 23b. Was decedent pregnant in t	he 23c. If yes, o	utcome of preg rth		etal death	3	Ectopic pregr	nancy	2	3d. Date of de Month	elivery Day	Year
Box 68760, e death certificate be execute the attending physician and ed for use as the burial - tran	icia	past 12 months?	1 7	ant at time of de		other (Spe				- 1			
Bo he dea the a	اچ		known 9 Unkno		11 1 1				100 - D	i d 4 - b			
ion of Vital Records, P.O. Box ttending Physician: The law requires that the death teath. stor: After this certificate has been signed by the atte the funeral director, page 2 should be detached for I	þ									_			
rds, requires	Completed								24a. W				sy findings available
COFC law re has be	휠					<u> </u>			aı	utopsy erformed?	pric		pletion of cause of
tal Rec cian: The certificate ector, page	등								1 ✓ Ye	es 2		Yes	2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medica examiner?	11				i Ot	Death (Check					
ing Physical After this funeral dir	은	1 Yes 2 No 27. Manner of Death	28a. Date of	patient 2	28b. Time of		28c. Injury a		ing Home 5		dence 6	Other:	
Division of Vital Records, ral or Attending Physician: The law requirers after death. **I Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	ē	1 Natural 5 Pen	(Month,	Day, Year)				s 2 No	subjec				
risic r Atte er des irecto	Ē	2 Accident Investigation 9///2003 10:43 all									Route Number, City		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:		Id not be (Specify)	unk					Salis	n, State) Sbury	, MD		
Hosp 24 hou Func		29a Certifier	hysician: To the best	of my knowled	ge, death occu	urred at the	e time, date	and place, an				stated.	
fo the vithin for the omple	edical		miner: On the basis of and manner sta		and/or investiga	ation, in m	y opinion, d	eath occurred	at the time, d	ate and p	lace, and due	to the c	ause(s)
F > F 0	Ž	29b. Signature and title of certific		1		29	c. License n				. Date signed		, Day, Year)
- V		alun	W	1			O.C.M.	E.		Au	gust 21, 2	011	
	Ì	30. Name and address of person	·			D - W	04 :	D - W	ND 0400				
l	- 1	Zabiullah Ali, M.D.	Assistant Medica	u Examiner	SUU VV.	paitimo	re orreet.	. paitimore	. IVIU 2122				

State 31. Date filed (Month, Day, Year) Registrar AUG 25 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 2:40 PM LaVerne Good Aug. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Month, Day, Hours Min. 1 X M 2 □ F 1946 PENNSYLVANIA Director 179-38-7176 65 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy njury or other traumatic event, the Medical Examina. 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 ី No DENVER PA LANCASTER 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 120 COUNTRY DRIVE USA 17517 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed Year or Dates. VIETNAM 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) AGRICULTURAL EQUIPMENT Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTURING FORKLIFT OPERATOR 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **ESTHER HERR** CLOYD GOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 WINDSOCK WAY, NEW HOLLAND, PA 17557 TIMOTHY GOOD/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State CENTER UNION CEMETERY 8/26/11 EAST EARL, PA 4 Donation 5 Other (Specify) Signature Funeral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that c. fised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause Ulsease or linjury Due to (or as a consequence of) has been signed by the attending physician and e 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 🗌 Unknown ision of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate ha performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours of To the Funeral Di completed filled r Medical 1 🌠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

are M

Laverne

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Atif Zeeshan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 4 2011

29c. License number

D0064120

29d. Date signed (Month, Day, Year)

Berlin

State of Maryland / Department of Health and Mental Hygien 20 1 - For State Registrar Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and n County of Death **Examiner** 4b. City, Town, or Location of Death 9. Birthplace (State or Foreign If Under 1 Year If Under 24 . Date of Birth 7. Age (In yrs. last birthday) Funeral Days (Month Day, Year 1 M 2 🗆 F Months Hours **Director** Usual Residence of Decedent show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No ambrio 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: If Yes, Give Year or Dates 'natural", Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 2 Page 1 and 2 should 19a. Informant's Name/Relationship (Type City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20c. Location 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State - 201 4 ☐ Donation 5 ☐ Other (Specify) 21. January o Funeral Service Licensee 22 Name and Add 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician oronary disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, If any leading to immedicause. Enter Underlying Cause (Disease or iinjury Due to jor as a consequence of for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached for 1 Yes 2 L 9 Unknown 9 Unknown Division of Vital Records, P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò To the Hospital or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) comit AUG 30 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

as

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Edward Hopkins Hammond, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional medical conter Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 6 9 1 M 2 □ F Min. 216-38-7842 5710 1942 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Worcester Berlin 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 South Main St. 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?
1 □XYes 2 □ No
If Yes, Give ō þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Law Firm Lawyer traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Grace Powell Edward H. Hammond, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 313 South Main St., Berlin, MD 21811 Elizabeth Hammond wife 20b. Place of Disposition (Name of cemetery, crematory or other p. St. Paul's Ch. 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State St. Church 9/4/2011 4 ☐ Donation 5 ☐ Other (Specify) Berlin, MD 22. Name and Address of Facility Burbage Funeral Home rvice Licensee helala 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ trauma multiple disease or condition resulting in death) Medical **Examiner** motor vehicle accident Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months? Yes 2 No 1 Yes 2 Unknown the 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Completed page 2 should 24a. Was an has autopsy certificate ☐ Yes 2 W No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ¥ Yes 2 □ No မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at Certificate: To the Hospital or Attending ☐ Natural 5 Pending work?
1 Yes 9/1/2011 2 **N**o 1120 2 Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town. State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, de person who completed cause of death (Item 23a) (Typ nos Smid PAYIO VD.O. OME DN 10+1

108 William St., Berlin, MD 21811 Approximate Interval Between nset and Death Naus 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Car accident 28f. Location (Street and Number or Rural Route Number, USSO, E. bound Whatequille, ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 1115/19 M.O. 100 E. CAPON St. SALISBUM, MD **ORIGINAL**

Year

2011

Black, White, etc.

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4:20 a August 25, 2011 Tear Physician/ Lucy P. Hurst Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carroll Westminster Golden Living Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Sep 21, 1919 Days Hours Months 1 🗆 M 2 💢 F 91 Tennessee 220-34-8158 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10c. City, Town or Location 10a, State should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director Taneytown 1 Yes 2 No Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21787 or items 23a Funeral 17144 Bull Frog Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11, Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. Specify white "natural" 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roxy Lane Luther Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai Robert Hurst, son 17144 Bull Frog Road, Taneytown, MD 21787 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place)
Keysville Union Cem 1 Burial 2 Cremation 3 Removal from State 8/30/2011 Keysville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 🗷 No Day page 2 should be detached for Pregnant at time of death 5 Other (specify) the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🕰 No 3 🗎 Probably 4 🗌 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, i 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖪 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? Natural injury 5 Pending Accident Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of certifier 29c. License number WIL 25 443 2011 3 who completed cause of death (Item 23a) (Type, Print) Westmuster, 688 Prolo 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Day 29 Year Physician/ Hall 05AM 201 Gertrude Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Arnold Future Care 8. Date of Birth (Month, Day, Yea Oct. 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** Months Davs Hours 1 □ M 2 🔀 F 86 1924 Maryland 219-16-3589 Director Usual Residence of Decedent 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director Severna Park MD Anne Arundel 1 Yes 2X No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral USA 21146 108 Hatton Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Hygiene. Medical Receptionist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental I uld be file Mental Myrtle Durner ည William Stinchcomb permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 21409 231 Wintergull Lane Leona Bermudez/Daughter Date 2, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) Sept 2011 1 X Burial 2 Cremation 3 Removal from State Glen Burnie, MD Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy. Sonature of Funeral Service License Severna Park Funeral Home Severna Park, MD 21146 P.A. 23a Part 1. E ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o' heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate vause (Final disease or ondition resulting in death) Pnysician/ CHRONIC MYELOID Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day in the past 12 months?
1 Yes 2 No Month ò Pregnant at time of death 1 ☐ Yes ∠ y 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes DEMENTIA peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 perform 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🔲 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours at To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) D57531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) microsville MD 21108 60 Velerans

Registrar
DHMH 17 Rev 7/2009

State

AUG 3 1 2011

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 2:38 P <u>Avis Virginia Hendrickson</u> August Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 87 Stewart Drive, Apt. 109 Edgewater Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days 1 🗆 M 2 😿 Hours Min. North Carolina 240-38-2243 87 Director May Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 1 Tes 2 X No Maryland Anne Arundel Edgewater 10e Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or Funeral USA 21037 87 Stewart Drive, Apt. 109 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: "natural" Completed 3 XWidowed 4 Divorced er than "natur , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene.

7 is marked other than raumatic event, the M Elementary/Seconday (0-12) Own Home 12th Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sallie Maie Melton 27 is marke Lester Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1110 South River Landing, Edgewater, MD 21037 permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troone. Roy Hicks/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🔲 Burial 2 🖵 Cremation 3 💢 Removal from State 4 Donation 5 Other (Specify) Raleigh National Cemetery 8/31/11 Raleigh, NC 21. Signature of 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform completed filled in by the funeral director, page 2 certificate 2 No 1 Yes Yes 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 W Residence 6 Other (Specify, After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **V** Natural iniury 5 Pending 1 Yes 2 No Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the I the 29d. Date signed (Month, Day, Year) 2 1000582

Registrar
DHMH 17 Rev 7/2009

State

2000 Medical Pkwy., Ste 607, Annapolis, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Young, M.D.

AUG 31

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) September 3, 20 11 Physician/ 6:00 aM Mary Louise Hall Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Sandy Spring Brooke Grove Rehab. and Nursing Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country $J_{\mathbf{u}}^{(Month,1)}$ 214-03-8598 1 M 25 TXF 103 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Sandy Spring Montgomery MD1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 20860 18131 Slade School Road, #124 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ρ 1 Never Married 2 Married SpecifyHite Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes Give 3 ☐xWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Secretarial Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပု Lillie May Paire John Peter Moran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 238 Concerto Avenue, Centreville, MD 21617 Mary E. Shipley/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 8, Sept. 2011 1 X Burial 2 Cremation 3 Removal from State Brentwood, MD Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final THROMBOSIS Physician/ CEREBRAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine physician and s the burial tressit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ♣ No
9 ☐ Unknown Month Day sate has been signed by the atterpage 2 should be detached for 4 Pregnant Pregnant at time of death P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 1 🗌 Yes 2 🗆 No certificate 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ျပ within 24 hours after death.

To the Funeral Director. After this rempleted filled in by the funeral director. this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c, License number D33700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTIZAN ST. WILLIAMSPORT, HOWE State 6

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Blanche K. Heath 15 PM 25,201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Viconica Salisbury Rehabilitationa Nursim If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth Funeral Hours 218-03-0117 1 □ M 2 🗶 93 Director Maryland Usual Residence of Decedent 10d, Inside City Limits 10a, State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f shore Examiner must be notified at Director 1 X Yes 2 No Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 21826 TISA 106 W. Main St. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. "natural", or Completed by 1 Never Married 2 Married Blanche H* 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meaonee. Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward P. Ford Blanche White 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 W. Main St., Fruitland, MD 21826 Theodore Cooke/Son 20b. Place of Disposition (Name of cemetery, crematory or other place, Wicomico Memorial 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/30/2011 Salisbury, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd. Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ADV ANCED Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Vear 5 Other (specify) Pregnant at time of death been signed by the s should be detached 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 autopsy has death? 1 ☐ Yes 2 ☐ No certificate Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? ျှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 Natural 5 Pendina iniury ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F complet 3 □ only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 8-25-11 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 378 GENESIS 200 Civic Ave. Solisbury MD 21804 TULLY KATE SAUS BURY 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:30 2011 September 6 Oscar Keller Harbaugh, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1019 Pope Ave. Hagerstown Washington County 8. Date of Birth (Month, Day, Year) Feb. 23,1922 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 XM 2□ F 214-28-7218 Maryland 89 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Mydical Experience must be notified at 1 X Yes 2 □ No Maryland Washington Director Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1019 Pope Ave. 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dives 2 DNo If Yes, Give 1940 – Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify. Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 1946 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Emissions Inspector U.S. Army Depot 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oscar K. Harbaugh, Sr. Lillian M. Brill Harbaugh ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Lapole-daughter 846 Frederick St. Hagerstown, MD 21740 Department of Health Important: If item 27 any injury or other trong. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 9-9-2011 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (c/di **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 NO 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 2 NO 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Tes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Mor

29b. Signature and title of certifier

and manner stated.

Name and address of person who completed cause of death (item 23a) (Type, Print)

tice certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

OPAL CT.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ AM LELAND ELIZABETH HYLE 0 201 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomic 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 24 Hrs. 8 Date of Birth **Funeral** 1 🗆 M 2 💢 F MAY 13 Months Min Year) 1944 MARYLAND 67 Director 218-42-7434 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2X No MARYLAND WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12626 TOROUAY ROAD 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married à Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) REGISTERED NURSE HEALTHCARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, FREDERICK HUESMAN **JEANNETTE** MALSTROM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12626 TORQUAY ROAD, OCEAN CITY, MD 21842 JOHN S. HYLE/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CREMATORY OF DELMARVA 8/31/11 DELMAR, DELAWARE 4 Donation 5 Other (Specify) . Signature of pureral Section Ligenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CARCINONA MALIGNANT disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 Division of Vital Records, P.O. been signed by should be detacl Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 3 Probably 4 Unknown 2 No 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 H No Other: HOSPICE Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certifier 29b. Signature 00058410

State Registrar 6 Huray

31. Date filed (Month, Day, Year)

SEP 01

SALISBUR

Name and address of person who completed cause of death (Item 23a) (Type, Print)

PO

BO

11-06240 UNK UNK - (le	velanz	State of Maryla	n Black if and / Depa	artment o	f Health a	and Mental I	Hygiene		20001	
lastis, III		1- For State Registrar			rtificate o			Re	g. No.	29984	
Physicia Medical Examii		Decedent's Name (First, M Cleveland)		, III				2. Date of Death Month August 19,		3. Time of Death 0018 hrs	
-		4a. Facility Name (if not instit	-	umber)	, or Location of Dea	ath					
Funanti	4	Peninsula Regional 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Salisbury		Irs. 8. Date of Birtl	n(MM/DD/YYYY) 9. Bir	thplace (State or	
Funeral Director		557-57-0076	3 X M 2 F	32	Yr		Days Hours M	5-6-1	1979 Foreig	n Puerto ^{untry} Rico	
b	1	Usual Residence of Deceden 10a. State 10b. Cour		10c City	, Town or Loca	tion				10d. Inside City Limits	
d how any			omico		isbury					1 X Yes 2 No	
darylar 28a-f s	Director	10e. Street and Number				10f. Zip Cod	le	10	g. Citizen of What Coul	ntry?	
th the N		300 E. Vine				2180			JSA	and Indian Plant	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4		cedent Ever in U Forces Mari 2 No	nes 🗥	res, specify Cul	ban, Mexican, Puer	Specify Yes or No- rto Rican, etc.) erto Ric	White, etc.	ican Indian, Black,	
ours af	g p	15. Decedent's Education (\$			16a. Decede	nt's Usual Occu	upation (Give kind o	of work done	16b. Kind of Business/	Industry	
16 n 72 h	Sete	Elementary/Secondary (0-	12) College (1-4 or 5+)		-		ourea)	Walmart		
d withi	Completed	17. Father's Name (First, Mid	Idle, Last)	<u> </u>	Sales	в рера	rtment 18.Mother's Name	me (First, Middle, M			
215 be file antal Hy rked o	a	Cleveland	A. Harris					Arcelu			
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medical	_	19a. Informant's Name/Relati		Wife					ber, City or Town, State		
and 2 fealth iften 2 traum		Josephine C 20a. Method of Disposition		20b.	Place of Disco.	sition (Name of	cemetery	Date	20c. Location - City or		
MOF Pages 1 ent of 1	١	1 Burial 2 X Crema 4 Donation 5 Other			rect (remat	ion, 8-	-30-2011	Dover, D	E	
Baltimore, permit. Pages 1 a Department of He Important: If ite		21. Signature of Funeral Sen	vice Licenseen	12-	22. Be1	Name and Addr	ress of Facility 9 1	7 W. Is	abella St		
Physician	4	23a. Part I Enter the disease	e, or complications that	caused the death	Fui	neral	Home Sa	lisbury	, MD ZIBU	Approximate Interval	
Medical		failure. List only one car Immediate Cause (Final dise	use on each line.							Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cocaine Intoxication Due to (or as a consequence of):									
	ě	Sequentially list conditions, if any, leading to immediate		a consequence	of):						
	Examiner	cause. Enter Underlying Cause (Ulsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
executed ian and ial - transit	ical Ey		d.	16	£b ~010	0 00	11				
O, e be exe sician burial -		X UNPENDED				9 9-20- er me,g	11 vt 919 9-28	-11 sm	23d. Date of deliver		
68760, certificate be nding physic se as the buri	an/M	IF FEMALE: 23b. Was decedent pregnant past 12 months?	in the 1 Live		2 F	etal death	3 Ectopic preg	gnancy		y Day Year	
Box 68760, e death certificate be the attending physic ref for use as the bur	Physician/Med	1 Yes 2 No 9		nant at time of d nown	eath 5 O	ther (Specify)					
at the d by the stached		Part II. Other significant cor	nditions contributing	to death but not	resulting in the	underlying caus	se given in Part I.		bacco use contribute to		
S, P, Luires the signer and signer ld be de	ed by	Morbid Obes	ity					1Yes - 24a. Was a		utopsy findings available	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stafer death. Tal Director: After this certificate has been signed by licd in by the funeral director, page 2 should be detach	Completed							autop:	sy prior to med? death?	completion of cause of	
Re The tifficate or, page	3	25. Was case referred to med	dical I			26.PI	lace of Death (Che	1 Yes 2	2 No 1 Y	es 2 No	
Vita nystcian this cer	, B	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA	Other Nur	sing Home 5	Residence 6 Othe	r:	
n of ding Pl	5	27. Manner of Death 1 Natural 5 F	(Mont	e of Injury th, Day,Year)	28b. Time of		Injury at Work? Yes 2 X No	28d. Describe h unknown	low injury occurred		
Sion Attender or death rector: by the	icati	2 Accident	nvestigation 28e Pla	-18-11 ce of Injury - At h	fd 11:1	o pm -		28f. Location (S	treet and Number or Ru	ural Route Number, City	
Divis	Certification:	4 Homicide	Could not be determined (Specify	found	d on st	reet		or Town, S Salisbu	tate)Rt. 13 & (.ry,Md	Carroll St.	
# 2 F 5		29a. Certifier 1 Certifying (Check only one) 2 Medical	g Physician: To the be Examiner:On the basis	est of my knowled of examination	dge, death occu and/or investiga	irred at the time	e, date and place, a nion, death occurre	and due to the caused at the time, date a	e(s) and manner as stated and place, and due to the	ted. ne cause(s)	
To the within To the comple	Medical	29b Signature and title of ce	and manner		100		ense number		29d. Date signed (Mo		
		Tielo El	afters	1/20/	7080	Ο.	C.M.E.		August 19, 2011		
		30. Name and address of per				V Ralina	o Ctroot Dalitie	noro MD 2422	3		
	ate	Victor Weedn MD		edical Exam		v. baitimore	e otreet, Baitin	nore, MD 2122			
Regist		31. Date filed (Month, Page)	40 WIII	know	p. 19	are					

DHMH 17 Rev 1/2001 OCME 2006

OCME

11-06470 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Glenn Albert Herzog State of Maryland / Department of Health and Mental Hygiene 29985 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day August 27, 2011 Medical Examiner 1331 hrs Glenn Albert Herzog 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10118 Bignonia Drive Laurel Prince George's 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Director 1 XM 2 F 52 12/07/1958 219-80-3083 Country) Texas Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show must be ootified at ooce, Prince George's Laure1 more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10118 Bignonia Drive 20708 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married White, etc. 1 Yes Specify: White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: the Medical Examiner <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Gaffer Entertainment 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Albert R. Herzog Kay Barbara Holroyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12810 Point Pleasant Dr., Fairfax, VA Kay B. Mongeon / mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 09/02/2011 Suitland, MD 4 Donation 5 Other Specify: Ignature of Funeral Service Licenses 22. Name and Address of Facility Advent Funeral Services 7211 Lee Highway, Falls Church, VA 22046 Physician disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Madical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the bunal - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Ę signed by the a Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has performed' death? ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) 8 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred the Fuoeral Director: Af Aug 27, 2011 1 Natural Subject shot 1301 hrs Pending 1 Yes 2 V No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 10118 Bignonia Drive, Laurel, MD determined 4 🗹 Homicide (Specify) At home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal To the 1 within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

OCME OCME

Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

State Registrar O.C.M.E.

August 28, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Kenneth Leonard Hubbard 1249 Medical Cacility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ALLBUM KICOMICO If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 🗆 F Year 1943 June 13, Maryland Yrs **Director** 218-40-5945 68 Usual Residence of Decedent shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f MD Wicomico Fruitland 1 X Yes 2 No ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 326 Holiday Street 21826 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give 1985-2 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white rr Yes, Give Year or Dates.1985-2003 "natural", 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) staff sergeant U. S. Army 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Norman Hubbard Rosalie Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Bonnie J. Hubbard wife 326 Holiday Street, Fruitland, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Page 1 1 K Burial 2 Cremation 3 Removal from State Maryland Veterans Cem! 9/1/11 4 Donation 5 Other (Specify) Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Ph. sician/ disease or condition more Medical resulting in death) Due to (or as a consequence of) **Examiner** per kns. Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a -transit certificate be executed Due to (or as a consequence of): resulting in death) Last the burial attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter for in the past 12 months? Pregnant at time of death signed by the a d be detached f 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No npleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and s of person who completed cause of death (Item 23a) (Type, Print) ElleOA 100 POHE

DHMH 17 Rev 7/2009

State Registrar 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Wicomico Regional medical center *alisbur* Date of billion (Month, Day If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** Sex 1 M 2 □ F Months Min **Director** NO permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Wes 2 No bury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Baltimore, Maryland 21215-0036 0 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify. 3 ☑ Widowed 4 ☐ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nor Ker Poultr Be 17. Father's Name (First, Middle, Last) ၉ UKE MMa 19a. Informant's Nam - Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Par Ker 9 Mie DYUMMel 20b. Place of Disposition (Name of openeter), crematory or other place) 1 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility
HENRY Funeral
510 Washingto Signature of Funeral Service Licensee Home, P.A. St. Cambr 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebro Vascular Accident Acute disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Struge End oh sease Sequentially list conditions, Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 068222 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. CARKOII KOZA M.D 100 31. Date filed (Month, Day, Year, 32. Registrar's Signature State SEP 07 and. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 0 Day **Physician** 2011 Sept. 9:45A ANNA MAE HANSON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cecil Calvert Manor Health Care Cntr. Rising Sun If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min 1921 1 M & F Months Hours Virginia 220-34-7348 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.1 show any Injury or other traumatic event, I'm Medical Experimer must be notified at once. 1 ☐ Yes 2 X No Whiteford Harford Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21160 USA 2032 Whiteford Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2√XNo Specify þ 3 Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amanda Phillips James Mullins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21154 3125 Tucker Road, Street, MD Michelle Comer/Granddaugh 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, MD 9/15/2011 Bel Air M.G. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Kely bling 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent preg 3 Ectopic pregnancy in the past 12 mod 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably known Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 400 1 ☐ Yes 2 2 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred medical examiner? Be 26. Place ___eath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) d title of certifier 29c. License number

State Registrar and ad

31. Date filed (Month, Day, Year)

2 0 2011

on who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 29989 Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Month AUGUST Physician/ Year 1/ 1735 James R. Jett Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince George's Prince George's Hospital Cheverly Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Months Davs Hours Nov. 30, Year 943 Director Washington, D.C 216-40-8580 67 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 Tes 2 No MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 U.S.A. 3208 Scarlet Oak Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Yes 2 XNo 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: 3 - Widowed 4 - Divorced White Completed and Mental Hygiene.

is marked other than "naturraumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10 College (1-4 or 5+) Heavy Equipment Bulldozer Operator Be 18. Mother's Name (First, Middle, Maiden Surname) Pauline Virginia Snellings 17. Father's Name (First, Middle, Last) ည Jack LaFonza Jett traumatic ie 1 and 2 should by t of Health and Mer If item 27 is marko 19a. Informant's Name/Relationship (Type, Print)
Diane E. Jett - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3208 Scarlet Oak Terrace, Bowie, MD 20715 item 2 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of h Important: If ite any injury or of cemetery grematory or other place)
MeadOwnidge
Memorial Park X Burial 2 ☐ Cremation 3 ☐ Removal from State 9-2-2011 Elkridge, Maryland Donation 5 Other (Specify) Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Enysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a cor the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death I signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 횬 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes Investigation Accident filled in by the Accider
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

KTEYENIS

31. Date filed (Month. Day.

MID

3001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar amended item#20-wchd-te-8/31/Prificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1845 23,2011 Vance W. Jones August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbu Peninsula Regional Medical Center Wicomico (State or Foreign Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F 84 11-18-1926 MD Director 218-20-5525 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifited at 1 ☐ Yes 2X No Director Bivalve MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA <u> 21814</u> 3494 Texas Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black White etc Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or iter 1X)Yes 2□No IfYes, Give Year or Dates: Army 1 Never Married 2 Married Vance JoneS Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specialack Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waterman 11 Oyster Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked ot any injury or other traumatic ever Mary-Delia Turner 2 James H. Jones, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3494 Texas Road, Bivalve, MD 21814 Altermease Jones/Wife 20c. Location - City or Town, State Dover, DE Date 20b. Place of Disposition (Name of 20a. Method of Disposition Directory Crematory Criber place LC 1 → Qurial 2 Cremation 3 Removal from State Elzey-UM-Cemetery 9-3-2011 Bivalve, -MD 5 ☐ Other (Specify) 4 Donation Bennie Smith 917 W. Isabella St. Signature 1 uneral Service Licensee 00 Funeral Home Salisbury, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final かしろ Physician disease or condition resulting in death) /Medical Due,to (or as a consult uence of) Pers Perlmany Discure Examiner would if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy atten for u Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 CUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed After this certificate funeral director, pag Yes 2 No or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ER/Outpatient 3 DOA 1 Inpatient r 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: Division 1 Natural 5 Pending To the nospin... within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) Salis be Nielwor Bordulu 200

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

inca ivy Jacksi)	1- For State Registrar	tate of Maryland	-	artment o <i>rtificate o</i>		ind Mental	-	Reg. No.	201	1 2999
Physic Medical Exam		Decedent's Name (First, Mide						2. Date of De	ath	Year	3. Time of Death 0350 hrs
1		4a. Facility Name (if not instituti		•	T	4b. City, Town,	or Location of De	Septemb		County of De	
		WB Suitland Road at 5. Social Security Number			look bildhala i	Suitland If Under 1 Y	and Killadas Od	time To Date of F		rince Geo	
Funeral Director		577-13-0761	1 M 2 X F	25	ast birthday) Yrs	Months D		Min. 01-08		Fo	Birthplace (State or reign Country)
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Loca	tion					10d. Inside City Limits
Maryland 28a-f show d at once,	Director	MD Prince	e Georges	Su	itland						1 Yes 2 X No
e Mary or 28a-		10e. Street and Number	7.1 // 1.00			10f. Zip Code			-	en of What C	ountry?
Dre, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland Health and Mornell Hygien. If item 27 is marked other than "matural", or items 33a or 28s-f sho her traumatic event, the Medical Examiner must be notified at once.		4244 Suitland 11. Marital Status	12. Was Deceden			20746 as Decedent of I	Hispanic Origin?	(Specify Yes or N		JSA 14. Race - An	nerican Indian, Black,
death or iten	Funeral		farried Armed Forces' 1 Yes 2	? X No			an, Mexican, Pue	erto Rican, etc.)		White, etc	
ırs after urai",	þ	3 Widowed 4 Di	vorced if Yes, Give Year or Dates: ecify only highest grade cor	mpleted)		Yes 2 X	No specify: pation (Give kind	of work done		Specify: ind of Busine	Black
5-0036 lled within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)					ife. DO NOT use		1.55.16		
within giene.	ошо	17. Father's Name (First, Middle	2 yrs.		Test T	echnici		me (First, Middle,			Technologies
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Keith Jackson	, Lasty					Gregory	Waldell	ourname)	
D 21 should ind Mer	To	19a. Informant's Name/Relations			1		eet and Number	or Rural Route Nu			
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Platells and Mental. Important: If item 27 is marked injury or other traumatic event,	-	Sheila Gregory 20a Method of Disposition			Place of Dispos	ition (Name of	ew St.	Philade Date			or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	I I	1 Burial 2 X Cremation 4 Donation 5 Other S		ale	crematory or ot		matory 9	-9-2011	Ale	xandri	a. VA
Salti ermit. Pepartm mports sjury o		21. Signature of Funeral Service	Licensee	1220				neral Ho			
Physician	2.5	23a. Part I. Enter the disease, or	complications that caused	I the death.	430)8 Suit1	and Rd.	Suitla	nd, N	4D 207	46 Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease		3							Between Onset and Death
ZABIIIIICI		or condition resulting in death)	Due to (or as a cons-	equence of	f):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of	f):						
	Medical Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	equence of	f):						
'60, cate be executed physician and ne burial - transit			d								
50, te be expysician		UNPENDED IF FEMALE:	AMENDED 23c. If yes, outcor	me of pregr	nancy				1 234	Date of deliv	904
ox 6876 eath certifical attending ph	ian/N	23b. Was decedent pregnant in the past 12 months?	he 1 Live birth		2 Fe		Ectopic pres	gnancy		Month	Day Year
Division of Vital Records, P.O. Box 68760, Bospital or Attending Physician: The law requires that the death certificate be executed busins after decent. Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be deached for use as the burial - transi	Physician/I	1 Yes 2 No 9 V Un		time of dea	atri 5 Ot	her (Specify)					
that the ned by detache	by Pt	Part II. Other significant condit	ions contributing to deat	h but not re	esulting in the u	inderlying cause	e given in Part I.			se contribute No 3 P	to the cause of death?
ds, equires	eted							- 24a. Was	an	24b. Were	autopsy findings available
ecor he law i te has t	Completed							_ auto perfo 1 ✓ Yes	ormed?	prior t death	
tal Recian: The certificate ector, page	Be Co	25. Was case referred to medica examiner?				26.Pla	ce of Death (Che				2 10
of Vit Physic er this eral dire	유	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatient 28b. Time of I		Other Nur	sing Home 5			ner: Scene
on of ending Pl sath. or: After the funera	Iţion	1 Natural 5 Pend	found: Day,Y	ear)	FOUND: 0246 hrs		Yes 2 V No	Driver of au			lision
ivisi lor At after d Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura or Town, State)								Rural Route Number, City	
Di Tospital 4 hours a ?uneral]		29a. Certifier	hysician: To the best of m			red at the time	date and place a				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical		miner: On the basis of examiner stated.								
11	ž	29b. Signature and title of certifie		_			nse number				Month, Day, Year)
- 4		30. Name and address if person	who completed cause of o	leath (Itom	23a)	0.0	S.M.E.		Septe	ember 3, 2	.011
1	1	Jack Titus MD. Dep	outy Chief Medical E	xaminer	900 W. E	Baltimore St	reet, Baltimoi	re, M D 21223			_
St Regis		31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	re						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene Registrar 25 per me, g920, 10/07/2011dhb Certificate of Death 29992 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Koben Year Johnson 2: 170 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Rathmine City, Town, or Location of Death **Examiner** Northwest andallestum Hupital Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Sex 1 X M 2 ☐ F NY Country) Months Hours Min. 7-21-1963 **Director** 095-58-1261 48 Usual Residence of Decedent Show 10b. County 10a. State If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2417 Molton Lane 21244 be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates sp Back 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Isadore Johnson Judy Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109-47 167th St, Jamaica, NY 11433 Judy Johnson/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Bonation 5 Other (Specify) Cremation, 8-25-2011 Dover, DE ^{22. Name and Address of Facility}917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 Ilgnature - Pan Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ontra Cramia Hemmhurge nysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner APPROVED BY MEDICAL EXAMINER Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a nonsequence of s been signed by the attending physician and should be detached for use as the burial-transit CERTIFICATION that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 s autopsy performed? Yes 2 No Hospital or Attending Physician: The 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Dispatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? death. Accident
Suicide
Homicide 2 No Investigation within 24 hours after deati To the Funeral Director: filled in by the 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certif Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Sign and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 20067210 2011

DHMH 17 Rev 7/2009

State

Registrar

30 Namo

31. Date filed (Month,

Day, Year)

AUG

4 2011

90

230,25

of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 30, 2011 Year Physician/ 2:50 Рм Sarah Jane King Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Denton Homestead Manor If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 □ M 2 🗓 F February II,1921 Indiana Director 265-03-5812 90 Usual Residence of Decedent show 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a, State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Denton Maryland Caroline 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21629 410 Colonial Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. δ 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: 3 XWidowed 4 Divorced White Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Accounting Adjudicator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Mary Jane Moore John Sexton Abercrombie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 Larch Court, Stevensville, Maryland Roberta K. Martin/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 8/31/2011 Dover, Delaware Capital Crematory 4 Donation 5 Other (Specify) Moore Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Lice's Denton, Maryland 21629 12 South Second Street, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Vascular accident Physician/ erebial disease or condition resulting in death)) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death
Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś demention 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performe Yes 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 23 examiner? Other: 4 Nursing Home 5 Residence 6 P Other (Specify) 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatlent 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) funeral (28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 31 WD 00053255 2011

State Registrar Choptank Rd

Preston MD 21655

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

683

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 20 I I Barbara September Kroboth Jean 7:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 451 W. Antietam St. Washington Hagerstown 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day
Dec 12 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 M Months Hours Year) 1945 Maryland Director 215-42-3280 65 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 451 West Antietam Street 21740 U.S.A. or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Black, White, etc. Armed Force 1 Never Married 2 Married þ 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 'natural", 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner / Operator Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pauline Domer Glenn Walter Magaha Haze1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra John J. Kroboth / Spouse 451 West Antietam Street, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemtery 9/10/2011 Hagerstown, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one caus Interval Between Onset and Death Immediate Cause (Final COPID Physician/ disease or condition resulting in death) sevent y rs Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned to the continued to 43 HD the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If <u>ye</u>s, outcome of <u>pr</u>egnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No signed by the atte Day Month Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🗷 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending w<u>or</u>k' 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe D14800

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Mon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

B. ALIZADEN

240 Frederick St. Hugerstow, HD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 5, 20 II Dorothy Mae Koontz 3:40 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Williamsport Williamsport Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Hours Feb. 16, 1921 Mary Tand 214-16-1533 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21795 201 South Vermont Street (Apt.B) 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?

1 Yes 2X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dry Cleaners Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guessford Florence Tosten Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12176 Cove Road Clear Spring, Maryland 21722 Patricia A. Lucas (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Williamsport, Maryland Greenlawn Mem. Park \$ept.8,2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility of Foneral Service Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 Tent 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE MENTHS disease or condition resulting in death) Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of) IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown

Ph.sician/ Medical **Examiner**

Physician/

Medical

Director

Funeral

þ

Completed

Be

٩

Examiner

Physician/Medical

Completed by

Be

ပ

Certificate:

Medical

Examiner

Funeral

Director

show or 28a-f shov notified at

items 23a or ner must be n

"natural", or item edical Examiner n

permit, Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical.

filed within 72 hours after death with the Maryland

Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

25. Was case referred to medical

2 🔀 No

6 Could not be

of certifier

examiner?

27. Manner of Death

Natural

☐ Accident ☐ Suicide

4 Homicide

29b. Signature and title

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. VENOUS THROWISOSIS.

24a. Was an autopsy

1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

performed' Yes 2 No 26. Place of Death (Check only one) Other:

Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 5 Pending Investigation

4 X Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D33700

SEPTEMBER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TED E. HOWE N. ARTIZAN ST. WILLIAMSPORT 154

31. Date filed (Month, Day, Year) SED

32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene	9996		
			1. Decedent's Name (First Middle Last)			
	Physicia Medi		Evelyn Kane Evelyn Kane Day Year O A O O O O O O O O O O O	S.15 PM		
	Examir	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at the Lake Salisbury Wicamica	,		
	Funeral Director			State or Foreign		
	3	Ŀ	Usual Residence of Decedent			
9036	Marylar 28a-f sh etified a	recto	Maryland Wicomico Salisbury	Inside City Limits 1 Yes 2 □ No		
	with the Is 23a or 2	Funeral Director	10e. Street and Number 27610 Riverside Drive Extd. 10f. Zip Code 21801 10g. Citizen of What Country? USA			
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	출	1 Never Married 2 Married 1 Yes 2 No Black, White, etc.			
21215-	within 72 ho giene. er than "na the Medic	Completed		γ		
yland	d be filed v Mental Hyg arked othe tic event,	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surname)			
Baltimore, Maryland 21215-0036	nd 2 shoul ealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print) Lois Haggerty/Child 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 27610 Riverside Dr., Extd., Salisbury, MD 2	21801		
	permit. Page 1 a Department of H Important: If ite any injury or otf		20a_Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Dotter (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 5t. Joseph Cemetery 8/25/2011 20c. Location - City or Town, 10cm of cemetery, NJ	State		
Bal	permit Depar Impor any in		22. Holloway Funeral Home Professional Ass 501 Snow Hill Rd., Salisbury, MD 21804	sociation		
	Physician	- 117	Integrated Councy (Final	proximate erval Between set and Death		
	Medical Examiner		disease or condition resulting in death) a. CAD IO WO ATH Due to (or as a consequence of):			
	d sit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or iinjury that imitated events resulting in death) Last b. VALVULAR IFRANT DISRASR Due to for as a consequence oil. The TRITIAN OBSTRUCTION Due to for as a consequence of:			
	ate be executed ohysician and the burial-transit		Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last C. Zutast INAL OBSTRUCTION Due to (or as a consequence of):			
3760	ficate be g physic ts the bi	ledical	d			
Box 687	hat the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Be Completed by Physician	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d.	Year		
ds, P.O.	sign be			-		
Division of Vital Records,	sician: The law requi s certificate has been lirector, page 2 should		24a. Was an autopsy fi prior to comple death?	tion of cause of		
ita	ician: certific ector,		25. Was case referred to medical examiner? 26. Place of Death (Check only one)	1 163 2/2-10		
λ	Phys r this c	3: To	1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Home 5 Residence 5 other (Specify)	08 p1 42		
o uo	anding sath. or: After he fune	Certificate:	28a. Date of injury 28b. Time of injury 28b. Time of injury 28c. Injury at work? 28c. Injury at work? 28d. Describe how injury occurred 28d. Describe how injury occurred 38d. Describe how injury occurred 38d. Describe how injury occurred 38d. Describe how injury occurred			
Divisi	tal or Attending rs after death. al Director: After ed in by the funer					
	To the Hospital or Attending Physician: The kawithin 24 hours after death. To the Funeral Director After this certificate hat completed filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.) and manner stated.		
	With Con		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, V			
	1518		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6HWAW CDARY P. BOP 1733 SAUBURY UP 218	0.7		
	Stat Registra	_	31. Date filed (Month, Day Year) 32. E-gistrar's Signature			
	negistra	'				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 Team Mabel Carlene King August 26, 10;51 aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Worcester 1135 Ocean Parkway 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 f Months Days Hours 08/23/1922 577-28-8777 89 Washington, DC Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 XYes 2 No Berlin Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1135 Ocean Parkway 21811 USA items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status the Medical Examiner Black, White, etc. or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. White Specify "natural", 3 X Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Security Officer traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H rtant: If item 27 is marked ot ည Mary Gatley Edward Donaldson 19a. Informant's Name/Relationship (Type, Print)
Carlene K. Williams/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30075 Southampton Bridge Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Ocean View Presbyterian 4 Donation 5 Other (Specify) 9/1/2011 Ocean View, DE Church Cemetery 22 Name and Address of Facility Holloway Funeral Home, Professional Association 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, CFSP 107 Vine St., Pocomoke City, MD 21851 Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Renal Failure as the burial-transit that initiated events resulting in death) Last and the attending physician certificate be Box 68760 IF FEMALE: nse 23b. Was decedent pregnant s, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d, Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown jo Dav ate has been signed by the a page 2 should be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hyperlipidemia, Multiple Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: Assisted Livin 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d, Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie d0067227 30 11 751C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Berlin, MD

Registrar DHMH 17 Rev 7/2009

State

Racetrack

1107

Registrar's Sign

DIC

Danielle

31. Date filed (Month, Day, Year) AUG 3 1 2011

Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 29999 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 AUĞÜST 30 18:30 MADELINE BUNTING Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthdav) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. DELAWARE Yrs. Director 221-56-5070 96 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 ☐ No **DELAWARE** SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19975 USA 8 EAST McCABE ST. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: "natura!", 3 X Widowed 4 Divorced Completed it. Page 1 and 2 should ce filed within 72 hour artment of Health and Mental Hygiene. cotant! If item 27 is marked other than "natuu injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GRISE KATIE MAX E. BUNTING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4416 MONMOUTH CASTLE RD., VIRGINIA BEACH, VA 23455 LORETTA L. MIESSE/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State BISHOPVILLE CEMETERY 9/7/11 BISHOPVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility Der Imp HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each lij e. node of dying wich as cardiac or respiratory arrest Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence or). and I-tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 month 1 Yes 2 No 9 Unknown Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No **Division of Vital** To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🔲 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending work thin 24 hours after death.

the Funeral Director: Af
empleted filled in by the fu 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: The best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24

To the F

complet 3 Certifying Nurse ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 50 Name and address of person

State Registrar

 $\bar{\Omega}$

#5%

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 30000 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Thomas G. Lynch 030 M 26,201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomic lisburu Rehabilitation (Nursing Cto If Under 24 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 1 M 2 □ F 7. Age (In yrs. last bithday) **Funeral** 72 Hours 10718/1938 004-36-5839 **Director** Maine Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Examiner must be notified at Director 1 Tes 2 No Maryland Wicomico Salisbury 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 615 Zion Road 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Air If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify White 3 Widowed 4 X Divorced Completed Force other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bus Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Helen Clark Thomas V. Lynch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29888 Deer Harbour Dr., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type, Print) Mark Lynch/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place, 8/30/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 21. Signatule of Funeral Service Licensee Hoffoway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No sate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably nce Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 NO. Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Tyes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature

State Registrar

INP

Ni Molay
31. Date filed (Month.

AUG

200

isje Avenue Salisbuy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)